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Alcohol and Drug Research Newsletter

'Let's talk about drugs'

media award winners 2013

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Ministers announce details of proposed Public Health (Alcohol) Bill

Minister of State Alex White, Minister for Health James Reilly, and Minister for Children and Youth Affairs Frances Fitzgerald announce measures to deal with alcohol misuse.

On 24 October 2013 Ministers James Reilly, Frances Fitzgerald and Alex White announced that the government had, at its cabinet meeting on 22 October, approved a number measures to be incorporated in a Public Health (Alcohol) Bill to deal with harmful use of alcohol.[1] The measures are based on the Steering Group Report on a National Substance Misuse Strategy,[2] which was published in February 2012 and contained 45 recommendations under the pillars of supply, prevention, treatment and rehabilitation, and research.

The table on page 2 summarises the recommendations of the Steering Group that require a legislative change, and the corresponding government measures to be provided for in the proposed Bill in relation to minimum unit pricing, alcohol advertising, sports sponsorship, and structural separation of alcohol from other products in mixed trading outlets.

In addition to the measures outlined overleaf, the proposed Bill will require that labels on alcohol products include the number of grams of alcohol per container, calorific content, and health warnings in relation to consuming alcohol in pregnancy. Public health messaging relating to alcohol will be based on grams of alcohol; weekly low-risk drinking guidelines will be 168 grams (17 standard drinks) for men and 112 grams (11 standard drinks) for women. The other measures set out in the Steering Group report are endorsed by government and will be progressed by the relevant departments and organisations as set out in that report.

International evidence suggests that raising the minimum price of the cheapest alcohol products reduces alcohol consumption and related problems, including mortality rates, crime and traffic accidents. Harmful drinkers tend to buy alcohol that is cheaper than that bought by low-risk drinkers. Cheap alcohol is also attractive to young people. So a minimum price policy is beneficial in that it targets the drinkers causing the most harm to both themselves and society while having little effect on the spending of adult low-risk drinkers.

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Public Health (Alcohol) Bill *(continued)*

Steering Group recommendation	Government measure
Minimum unit pricing	
Introduce a legislative basis for minimum pricing per gram of alcohol.	Set a minimum price per gram of alcohol in the product. This will target low-cost products in the off-trade, especially supermarkets.
Alcohol advertising	
Introduce a statutory framework with respect to the volume, content, and placement of all alcohol advertising in all media in Ireland (including the advertising of pubs or clubs). This will involve the utilisation of existing legislation (such as the Broadcasting Act 2009) as well as the development of new legislation. At a minimum the legislation and statutory codes should provide for: • a 9.00 p.m. watershed for alcohol advertising on television and radio; • alcohol advertising in cinemas to only be associated with films classified as being suitable for over-18s; • prohibition of all outdoor advertising of alcohol; and • all alcohol advertising in the print media to be subject to stringent codes, enshrined in legislation and independently monitored.	• Limit advertising of alcohol on television and radio to evening hours from 2016. • Limit advertising of alcohol in cinemas to films classified as over 18s • Restrict advertising of alcohol in outdoor media from 2018, with a statutory code of practice to govern such advertising in the interim. o Work will be undertaken with relevant government departments to put in place a process which will identify the forms, frequency and prevalence of outdoor media advertising to be either encompassed or exempted from any restrictions. • Regulate advertising of alcohol in print media by way of a statutory code. • Set limits on how alcohol is portrayed in advertisements.
Sports sponsorship	
Drinks industry sponsorship of sport and other large public events in Ireland should be phased out through legislation by 2016. In the intervening time, it should not be increased.	Place on a statutory footing the existing voluntary code that governs sports sponsorship. A working group chaired by the Department of An Taoiseach will report within 12 months on i) the value, evidence, feasibility and implications (including the public health consequences for children and young people) of regulating sponsorship by alcohol companies of major sporting events; and ii) its consideration of financial implications and alternative sources of funding for sporting organisations to replace potential lost revenue arising from any such regulation.
Structural separation	
Commence Section 9 of the Intoxicating Liquor Act 2008, which provides for the structural separation of alcohol from other products in mixed trading outlets, including supermarkets, convenience stores and garage forecourts.	• Replace the current voluntary code with a statutory code under Section 17 of the Civil Law (Miscellaneous Provisions) Act 2011. After two years the Departments of Justice and Equality and of Health will review the statutory code's effectiveness in achieving the policy objectives of Section 9 of the Intoxicating Liquor Act 2008.

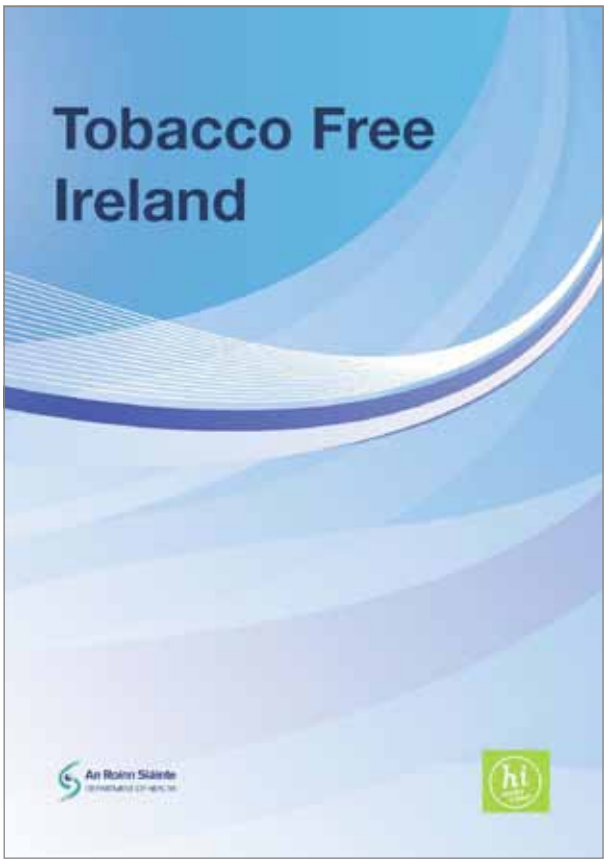
Source: Steering Group report Ch. 7, and DoH press release

There is clear evidence that alcohol marketing, including advertising, sponsorship and other forms of promotion, increases the likelihood that adolescents will start to use alcohol, and to drink more if they are already using alcohol. The World Health Organization recommends restricting the volume and content of alcohol marketing communications as a way of reducing alcohol-related harm. While the proposed Bill does place certain limits on alcohol marketing, it either applies these limits in a much more restrictive manner than recommended by the Steering Group or delays the implementation of these limits significantly, and in the case of sports sponsorship, indefinitely.

(Deirdre Mongan)

1. Department of Health (2013, 24 October) *Minimum unit pricing and regulation of advertising and sponsorship to be provided for in a Public Health Bill.* Press release issued by the Department of Health on the announcement of the proposed Bill. www.dohc.ie/press/releases/2013/20131024.html
2. Department of Health (2012) *Steering Group report on a national substance misuse strategy.* Dublin: Department of Health. www.drugsandalcohol.ie/16908

A tobacco-free Ireland by 2025?



On 3 October 2013 the Minister for Health, James Reilly TD, launched *Tobacco free Ireland*, the government's revised policy on tobacco control.[1] It sets a target of a tobacco-free Ireland in 12 years' time, which it defines as 'the achievement of a smoking prevalence rate of less than 5% of the Irish population by 2025. Tobacco will still be available but at a higher price and in restricted outlets.'

The aspiration

While the overall aim of Ireland's tobacco control policy is harm reduction, i.e. 'unnecessary and preventable deaths and disability', the government has upped the ante by calling for a tobacco free society 'where people can live longer and healthier lives, free from the detrimental effects of tobacco'. To achieve this outcome the new policy document identifies two things that must happen – a decrease in smoking prevalence, and a 'denormalisation' of tobacco within society. The former will be realised through employing both population-based approaches (focusing on the whole population) and risk-based approaches (targeting high-risk groups such as children and adolescents, smokers in low-income groups and young women). The latter will require generating public support for policies leading to a tobacco-free society

The evidence base

The first five chapters of the policy document review the evidence on the basis of which the Tobacco Policy Review Group has developed the new aspiration. The Review Group reports that the most recent data gathered by the National Tobacco Control Office, which monitors cigarette-smoking prevalence and behaviour on a monthly basis, show that the overall prevalence of cigarette smoking in Ireland has declined from just under 24% in June 2010 to 22% in June 2012.[2] The Group also comments that policy interventions have been instrumental in reducing tobacco consumption, and have also impacted positively on health; for example, a recent study estimates that the 2004 workplace smoking ban in Ireland has led to the avoidance of more than 3,500 deaths that would have occurred owing to tobacco consumption.[3]

The framework for action

The ambitious new tobacco-free aspiration is set within the policy framework put in place 13 years ago, in the previous tobacco control policy document – *Towards a tobacco free Ireland*.[4] Four additional themes are emphasised in the new policy framework:

Protecting children

- This is to be prioritised in all initiatives.

Denormalisation of tobacco use

- Legislation to prohibit smoking within the campuses of primary schools, secondary schools and child care facilities is to be introduced.
- Tobacco free campuses for all third-level institutions, and for all health care, governmental and sporting facilities, are to be promoted.
- Tobacco free playgrounds, and also parks and beaches, to be promoted in conjunction with local authorities.
- Tobacco free environment initiatives will be evaluated with a view to the introduction of legislation needed.

Building and maintaining compliance with tobacco legislation

- Promote compliance with and enforce all provisions of the Public Health (Tobacco) Act 2002 as amended.
- Introduce on-the-spot fines for offences.
- Develop capacity within the HSE's Environmental Health Service to enforce all aspects of the tobacco control legislation.
- Develop special investigation capacity within the HSE's Environmental Health Service to assess compliance by tobacco manufacturers.
- Introduce legislation for the publication of information in respect of any person on whom a fine, other penalty or conviction was imposed by a Court, i.e. name and shame.
- Collaborate with other EU countries in relation to compliance measures for tobacco ingredient reporting.

Regulating the tobacco retail environment

- Develop a licensing system for retailers who sell tobacco products.
- Prohibit sales of tobacco in mobile units/containers.
- Prohibit the sale of tobacco at events/locations primarily intended for persons aged under 18 years.
- Prohibit the sale of tobacco products by those aged under 18 years.

A tobacco-free Ireland by 2025? *(continued)*

- Prohibit the operation of all self-service ending machines.
- Introduce a minimum suspension period for retailers convicted of an offence.

The WHO MPOWER model

The policy framework is further informed by the MPOWER model,which was developed by the World Health Organization to enable countries to implement the Framework Convention on Tobacco Control (FCTC) measures. The model identifies the six most important, effective and evidence-based tobacco control policies:

- **M**onitor tobacco use and prevention policies
- **P**rotect people from tobacco smoke
- **O**ffer help to quit tobacco use
- **W**arn about the dangers of tobacco
- **E**nforce bans on tobacco advertising, promotion and sponsorship
- **R**aise taxes on tobacco products

The Review Group recommends 35 specific actions that need to be undertaken in the Irish context, including research and data collection, legislative measures, social marketing campaigns, development of guidelines and training health professionals.

The next steps

The Review Group calls for a detailed action plan to be developed outlining the timeframes and responsibilities for the implementation of its recommendations. It repeats the call already made in *Healthy Ireland,*[5] the policy framework for improved health and wellbeing launched earlier this year, which states that positive changes in health and wellbeing require the whole community, the whole of government and all of society to work in unison.[6]

(Brigid Pike)

1. Tobacco Policy Review Group (2013) *Tobacco free Ireland.* Dublin: Department of Health. www.drugsandalcohol.ie/20655/
2. For further information visit www.ntco.ie
3. Stallings-Smith S, Zeka A, Goodman P, Kabir Z and Clancy L (2013) Reductions in cardiovascular, cerebrovascular, and respiratory mortality following the national Irish smoking ban: interrupted time-series analysis, *PLoS ONE* 8(4): e62063. doi:10.1371/journal.pone.0062063. www.drugsandalcohol.ie/19756/
4. Tobacco Free Policy Review Group (2000) *Towards a tobacco free society*. Dublin: Stationery Office. www.drugsandalcohol.ie/5337/
5. Department of Health (2013) *Healthy Ireland – a framework for improved health and wellbeing 2013–2025*. Dublin: Department of Health. www.drugsandalcohol.ie/19628/
6. Pike B (2013) Healthy Ireland – implementation matters. *Drugnet Ireland* (46): 15–16. www.drugsandalcohol.ie/20136/

Alcohol Action Ireland conference on alcohol and mental health

Alcohol Action Ireland held a conference entitled 'Facing 'The Fear': alcohol and mental health in Ireland' on 20 November 2013. The conference was opened by Minister Alex White, who confirmed the government's commitment to introduce minimum unit pricing in 2014. Dr Bobby Smyth, consultant child and adolescent psychiatrist, stated that teenagers are drinking at an earlier age than in previous generations, and upon entry into adulthood most young people in Ireland are drinking in a harmful manner. He described the risks that this posed to young people's brains and their ability to learn effective and proactive coping strategies.

Professor Ella Arensman, director of research with the National Suicide Research Foundation, said that in 2012 the average daily number of self-harm presentations to hospital across the state was 33. Alcohol was involved in 38% of these presentations (42% in men, 36% in women). She said that alcohol is one of the factors contributing to high rates of self-harm among young people and adults because of the depressive effect of heavy drinking. She also recommended more active consultation and collaboration between mental health and addiction services in organising treatment for patients who presented with the dual diagnoses of psychiatric disorder and alcohol or drug abuse.

Consultant psychiatrists Dr Conor Farren and Dr Philip McGarry also described the relationship between alcohol and mental health. This was followed by a discussion about the human cost of alcohol and the role of alcohol in suicide, particularly among young people. The speakers were Dr Claire Hayes, clinical director of Aware, Ireland's depression support charity, Mr John Higgins, a Mayo father whose 19-year-old son, David, died by suicide in 2011, and Fr Pat Seaver, a Limerick priest who has supported families who have been bereaved by suicide and has voiced his concerns about the role of alcohol in these tragedies.

(Deirdre Mongan)

Dr Bobby Smyth, consultant child and adolescent psychiatrist, speaking at the AAI conference

A 'healthy Ireland' in a 'healthy Europe'

Healthy Ireland, Ireland's framework for improved health and well-being,[1] is informed by *Health 2020,* the World Health Organization's (WHO) policy framework and strategy for improving health for all and reducing health inequalities among citizens of the 53 member states of the WHO European Region, including Ireland.[2]

The product of an extensive two-year consultation process across the European region and beyond, Health 2020 concentrates on two strategic objectives:

1. To improve health for all and reduce health inequalities by developing universal policies to improve the health of everyone and so reduce the absolute effect of social determinants on all people, targeting interventions to focus on those most affected, and developing policies to address the social gradient in health directly, through interventions that are proportionate to the level of health and social need.
2. To improve leadership and participatory governance for health by more effectively engaging broad public participation in policy-making, addressing the demand to consider public values, priorities and concerns, and adopting approaches that build community resilience, social inclusion, cohesion and assets for well-being.

Under these strategic objectives, the framework sets out four priorities. Drugs, alcohol and tobacco are mentioned under three of these priorities.[3]

Priority 1: Invest in health through a life-course approach and empower citizens

Tobacco, alcohol and illicit drugs are covered in relation to children and adolescents, and vulnerable groups, specifically migrant groups and Roma. The framework calls for integrated approaches and joint working.

- Children and adolescents: Joint working by the health, education, social protection and labour and employment sectors may be assisted by a framework of accountability of each sector for the health of children and adolescents and health-related issues, for example via a set of jointly owned targets and indicators, linked to financing. Developing a national health information system with well-defined indicators would also allow trends in the health and development of children and young people to be monitored, both for the population as a whole and across the social distribution.
- Migrants: Policies to promote social inclusion might include measures to combat discrimination across a range of sectors including education, employment, social protection, housing and environment, health.

Priority 2: Tackle Europe's major disease burdens of non-communicable and communicable diseases

Together with physical inactivity and unhealthy diet, alcohol use and tobacco use are listed as key behaviours that aggravate the onset of some of the most common non-communicable diseases including cardiovascular disease, cancer, diabetes and mental disorders. In this context, tobacco control interventions are identified as the second most effective way to spend funds to improve health, after childhood immunisation, and increasing the price of tobacco through higher taxes as the single most effective way to reduce tobacco consumption and encourage tobacco users to quit.

To reduce the harmful use of alcohol, options listed in the framework include:

- domestic taxation on alcohol, accompanied by an effective enforcement system;
- regulating the days and hours of retail sales;
- establishing an appropriate age for purchasing and consuming alcoholic beverages, and other policies to raise barriers against sales to and consumption of alcoholic beverages by adolescents;
- an upper limit for blood alcohol concentration, with a reduced limit for professional drivers and young or novice drivers;
- promoting sobriety checkpoints and random breath-testing;
- supporting initiatives for screening and brief interventions for hazardous and harmful drinking in primary health care and other settings, which should include early identification and management of harmful drinking among pregnant women and women of child-bearing age; and
- developing effective co-ordination of integrated and/or linked prevention, treatment and care strategies and services for alcohol-use disorders and comorbid conditions, including drug-use disorders, depression, suicide, HIV infection and TB.

A 'healthy Ireland' in a 'healthy Europe' *(continued)*

Injuries, be they intentional or unintentional, are responsible for 9% of the deaths in the WHO European Region but 14% of the burden of disease. Within countries, injuries and violence are strongly linked to socio-economic class and cause health inequities. There are cross-cutting risk factors for the different types of injury, such as alcohol and drug misuse, poverty, deprivation, poor educational attainment and unsafe environments. The WHO policy framework emphasises that developing preventive strategies requires addressing the underlying structural factors and modifying individual and population-level risk behaviours.

With regard to communicable diseases, the WHO European Region is experiencing serious challenges in the rates of TB and HIV infection, among other diseases. The re-emergence of TB is linked to a failure of health systems to implement services that are responsive to people's needs. Although TB is not the exclusive preserve of any social class, the disease is often linked to poor socioeconomic conditions and other determinants, including crowded accommodation and homelessness. As with HIV, people who inject drugs and prisoners are at higher risk of acquiring TB, as are alcoholics and homeless people. Moreover, TB and HIV infection are a deadly tandem, as TB is a leading killer among people living with HIV.

Priority 3: Strengthen people-centred health systems and public health capacity

The need to refocus health care services around people's needs and expectations and to make them more socially relevant is seen as the main challenge in reforming health services. The WHO policy framework notes that particular attention needs to be paid to low-income and vulnerable populations, such as internal and external migrants, Roma populations, groups living in remote mountainous areas and drug users. Outreach programmes and other new models of delivery that can reach these difficult-to-reach groups need to be developed.

(Brigid Pike)

1. Department of Health (2013) *Healthy Ireland: a framework for improved health and wellbeing 2013–2025*. Dublin: Department of Health. www.drugsandalcohol.ie/19628. See also commentary at Pike B (2013) Healthy Ireland – implementation matters. *Drugnet Ireland*, (46): 15–16. www.drugsandalcohol.ie/20136
2. World Health Organization (2013) *Health 2020: a European policy framework and strategy for the 21st century*. Copenhagen: WHO Regional Office for Europe. www.drugsandalcohol.ie/20480. In 2012 the Health 2020 policy framework was adopted by the 53 member states of the WHO European Region. In 2013 the WHO Regional Committee for Europe published *Health 2020* in two forms: a shorter policy framework, which sets out the main values and principles, and a longer policy strategy, which gives more detail regarding evidence and practice.
3. The other priority is 'Creating resilient communities and supportive environments'.

Towards UNGASS 2016

This column reports on policy initiatives, research and debates launched in UN member states and by civil society organisations that are relevant to the UN General Assembly Special Session (UNGASS) on the world drug problem, scheduled for 2016 (A/RES/67/193).[1]

Psychoactive substances – New Zealand and the EU

In July 2013 New Zealand's parliament passed by 119 to one the Psychoactive Substances Act. The Act regulates the importation, manufacture and supply of psychoactive substances, which are defined as substances, mixtures, preparations, articles or devices capable of producing a psychoactive effect in the individual who uses them. The law specifically excludes substances such as alcohol, tobacco, and pharmaceuticals. The legislation establishes a Psychoactive Substances Regulatory Authority within the Ministry of Health. This Authority is responsible for ensuring products meet adequate safety requirements before they can be distributed in New Zealand. The Authority also licenses importers, researchers, manufacturers, wholesalers and retailers. The sale and advertising of psychoactive products are strictly controlled and no-one under the age of 18 is permitted to buy or possess them. All products must be labelled with health warnings, a list of the active ingredients, contact details for the manufacturer or distributor, and the telephone number of the National Poisons Centre. The Regulatory Authority can withdraw a product from the market if adverse effects, including reports of addiction, are confirmed.

The purpose of the legislation is to 'regulate the availability of psychoactive substances in New Zealand to protect the health of, and minimise harm to, individuals who use psychoactive substances'. Despite a call to adopt legislation similar to Ireland's Criminal Justice (Psychoactive Substances) Act 2010, the view was taken that the so-called Irish model of banning substances had been tried in New Zealand since 2008 and had failed.

Under the New Zealand Act, risk is assessed and dealt with as follows:

- the degree of harm posed by a product to individuals who use it is assessed by the Authority on the basis of advice from an expert advisory committee, and evidence, including the results of preclinical and clinical trials;
- a psychoactive product that poses no more than a low risk of harm to individuals who use the product is approved;
- a psychoactive product that poses more than a low risk of harm is prohibited;
- on a precautionary basis, psychoactive products are prohibited until they have been approved by the Authority.

For the Act and its implementation, see www.health.govt.nz/our-work/regulation-health-and-disability-system/psychoactive-substances/
For background and policy analysis, see McCullough C, Wood J and Zorn R (2013) *New Zealand's psychoactive substances regulation.* IDPC/NZDF Briefing Paper. http://idpc.net/publications?profiles=278

Towards UNGASS 2016 *(continued)*

On 17 September 2013 the European Commission proposed to strengthen the EU's ability to respond to 'legal highs'. The Commission's proposal would enhance the EU's current response in two ways:

1. The EU would be able to act within 10 months, instead of two years as at present. In particularly serious cases, the EU would be able to withdraw a substance immediately from the market for one year. This would ensure the substance is not available to consumers until a full risk assessment has been carried out.
2. The new system would allow for a graduated approach where substances posing a moderate risk would be subject to consumer market restrictions, substances posing a high risk to full market restrictions, and only the most harmful substances, posing severe risks to consumers' health, to criminal law provisions, as is the case for illicit drugs.

The Commission's proposals need to be adopted by the European Parliament and by the Council of the EU in order to become law.

For more details, see European Commission press items: IP/13/837 and MEMO/13/790

Cannabis – Uruguay and Ireland

On 31 July 2013 Uruguay's lower house of parliament voted by 50 to 46 to create a legal cannabis market. Key provisions include:

- Licensed consumers will be able to grow up to six plants at home.
- Growing clubs with a specified membership ceiling will be able to grow up to a specified maximum of cannabis plants.
- Private companies will be able to grow cannabis but the harvest must be sold to the government, which will sell this output in licensed pharmacies.
- Only those aged 18 or over will be permitted to access cannabis for recreational use.
- Consumption will be restricted to 40 grams per month.
- A confidential federal register of users, home growers and membership clubs will be maintained to ensure traceability and control of cultivation and use, including deterring 'drug tourism'.
- An Institute for Regulation and Control of Cannabis will be established to grant licences for all aspects of the industry.
- Comprehensive prevention, harm reduction and treatment measures will be provided to ensure the risk of and harms associated with problematic cannabis use are tackled.
- An independent evaluation and monitoring unit will be established to report annually on the implementation and impact of the new law.

On 10 December 2013 Uruguay's upper house of parliament, the Senate, passed the Bill legalising and regulating the production and sale of cannabis in Uruguay. The law is due to come into force in the new year.

For more details see www.tdpf.org.uk/blog/history-made-uruguay-mps-vote-legally-regulated-cannabis

On 12 December 2013 the Transform Drug Policy Foundation (TDPF) published *How to regulate cannabis: a practical guide*. It guides policy makers through the practical challenges in developing and implementing effective systems of legal regulation. http://www.tdpf.org.uk/resources/publications/how-regulate-cannabis-practical-guide

On 5–6 November 2013 Dáil Éireann debated a private member's motion that the government introduce legislation to regulate the cultivation, sale and possession of cannabis and cannabis products in Ireland. The motion was defeated. On 20 November Ming Flanagan, TD for Roscommon/Leitrim, who tabled the motion, introduced a private member's bill to provide for the regulation of cannabis for medicinal and recreational use. The Cannabis Regulation Bill 2013 provides for the establishment of a Cannabis Regulation Authority, for licensing the cultivation and sale of cannabis, and for offences. Although the Bill adopts a similar approach to the Uruguayan legislation, the regulation of the cannabis market is less restrictive. The Bill provides for a range of licences for selling cannabis including wholesale, retail store, medicinal cannabis retail, cannabis coffee shop and cannabis social club. Instead of maintaining a register of users, home growers and membership clubs as a means of preventing drug tourism, the Irish Bill simply requires those licensed to grow or sell cannabis to have been legally resident in Ireland for the two years prior to applying for their licence, and those purchasing cannabis products to be either a citizen of the EU or legally resident in Ireland.

For the debate, see http://oireachtasdebates.oireachtas.ie/debates%20authoring/debateswebpack.nsf/datelist?readform&chamber=dail&year=2013.
For the Cannabis Regulation Bill 2013 see http://www.oireachtas.ie/viewdoc.asp?DocID=24824&&CatID=59

(Brigid Pike)

1. While every effort has been made to describe a representative range of initiatives, from a variety jurisdictions and civil society organisations, it is not possible to provide comprehensive coverage.

Decriminalisation: CityWide urges informed debate

In November 2013, Senator John Crown launched a CityWide Drugs Crisis Campaign leaflet aimed at progressing debate in Ireland on the subject of drug law reform in general and decriminalisation in particular.[1] Father Peter McVerry SJ and Liam Herrick, executive director of the Irish Penal Reform Trust, also spoke at the launch.

The publication of the leaflet follows on from a conference organised by CityWide earlier this year when a number of speakers addressed the topic 'Criminalising addiction: is there another way?'[2] At the conference, according to the leaflet, 'the most frequent comment from attendees was that they had not fully understood the difference between decriminalisation and legalisation and that they were unaware of the way decriminalisation has worked in other countries' (p.4). The purpose of this leaflet is to provide basic information and sources of further information to inform the debate.

The leaflet begins by distinguishing between decriminalisation and legalisation. Legalisation is described as a process whereby the importation, sale, purchase and use of drugs is regulated by the state in the same way as alcohol and tobacco. With decriminalisation, drugs would remain illegal, but a person found in possession of drugs for personal use would not receive a criminal sanction. Instead, 'depending on the circumstances, they could be given a warning, a fine or be directed to drug awareness classes or to drug treatment' (p.1). The importation of drugs, drug trafficking and the commission of crimes to fund drug use would still be prosecuted under the criminal law.

The leaflet identifies a number of reasons why Ireland should consider the decriminalisation of drugs for personal use. Criminalisation 'does not act as a deterrent when someone decides to use drugs but it does cause significant harm to an individual's future prospects as the requirement to disclose previous convictions never lapses' (p.2). Furthermore, decriminalisation, by directing problematic drug users into treatment programmes rather than the criminal justice system, for example, would reduce criminal costs and allow money to be redirected towards tackling organised crime.

In the past decade, 'over 25 countries across the globe have introduced decriminalisation models'. The leaflet highlights the model introduced in Portugal in 2001[3] where 'addiction and drug use are treated as public health issues rather than criminal justice issues'. This approach has had a number of positive outcomes, including the following:

- a reduction in drug-related harms and a decline in drug use among the most vulnerable population – young people and problematic users;
- a significant decrease in drug-related deaths;
- a major reduction in prison overcrowding;
- a reduction in the number of young people becoming dependent on opiates;
- a significant reduction in the transmission of HIV and blood borne viruses. (p.3)

Noting the emphasis on evidence-based policy in the National Drugs Strategy, CityWide asserts that 'there is now a significant evidence base on the impact of criminalisation of drugs for personal use and on the experience of decriminalisation' (p.4). This information should, according to CityWide, inform Ireland's contribution to UNGASS 2016.[4]

This is a timely and brave initiative from a community-based organisation that represents the people most seriously affected by the drugs crisis. Kornblum (1993:132), writing from the perspective of minority ghettoes in the US about attempts to liberalise drug laws, notes how such proposals 'generate little support in the ghetto communities where their sale and use has had the most pernicious effects… few proposals for dealing with the drug problems of minority communities will receive much support from those communities unless they are viewed as originating from the communities themselves'.[5]

(Johnny Connolly)

1. CityWide Drugs Crisis Campaign (2013) *Decriminalisation: a new direction for drugs policy*. Dublin: CityWide. www.drugsandalcohol.ie/20698
2. The conference was organised on foot of a commitment made by CityWide in 2012 to hold an open debate on decriminalisation. See Higgins M (2012) *The drugs crisis: a new agenda for action*. Dublin: CityWide. www.drugsandalcohol.ie/17145. A written report on the conference and videos of the presentations are available at www.citywide.ie/news/2013/05/27. See also *Drugnet Ireland*, (47):7–11.
3. Connolly J (2009) Reports examine effects of decriminalisation of drugs in Portugal. *Drugnet Ireland*, (30): 22–23.
4. For more information about UNGASS 2016 see the article in this issue of *Drugnet Ireland*.
5. Kornblum W (1993) Drug legalization and the minority poor. In Bayer R and Oppenheimer G (eds) *Confronting drug policy: illicit drugs in a free society*. New York: Cambridge University Press.

CityWide groups meet to plan renewed campaign

Community groups and representatives, supported by the National Voluntary Drug Sector, held a campaign meeting on 23 October in a Dublin city centre hotel.[1] Setting the meeting in context, Anna Quigley of Citywide Drugs Crisis Campaign stated:

> All the evidence confirms that our communities are now coping with an increasingly complex and chaotic drug problem that includes a mix of legal drugs, illegal drugs and alcohol. Within this mix, there are different patterns of drug use in different areas and for different age groups but there is one common thread – the enduring link between disadvantage and serious community drug problems.

She also identified a 'gradual and continuing decline in political will to address the drugs problem over the last number of years.'

In support of this contention, and keeping in mind the history of the National Drugs Strategy with its focus on a partnership approach reflected in the establishment of local drugs task forces, and liaison between state agencies and government departments, Quigley observed: 'For the first time since the Rabbitte Report in 1996, there has been no national drugs co-ordinating committee in place for most of the past year and proposals for a new committee are continuously being put on hold.' These themes were further underlined in the opening section of the meeting in a short DVD featuring the six people who represent the community sector on national bodies.[2]

Social and economic analyst Brian Harvey showed how the community and voluntary sectors and the services that they deliver have been particularly targeted for cuts in recent years, both through policy and funding decisions.[3] Severe financial cuts since 2002 have, he said, resulted in a 37% reduction in the drugs initiatives budget between 2008 and 2014. This erosion of funding, he pointed out, contrasts with a 7.1% cut in overall government spending.

This presentation was followed by workshops where participants were asked to respond to the question 'What are the main ways in which drugs are impacting on your community now?'

The following key drug problems were identified across all workshop groups:

- reduction and depletion of community resources and services;
- drug-debt-related intimidation and drug-related violence in communities;
- decline in physical and mental health of drug users, and premature deaths;
- concerns about young people engaging in harmful practices;
- the normalisation of drug use and drug taking in communities; and
- concerns and impacts of polydrug use.

Following a short question and answer session, it was agreed at the meeting that a number of short video clips, with messages about what is happening in communities, would be prepared by CityWide for use on social media and for circulation to politicians and others. Also, the meeting called for Alex White TD, Minister of State at the Department of Health with special responsibility for the National Drugs and Alcohol Strategy, to set a date for convening the National Co-ordinating Committee on Drugs. Finally, it was agreed that a major campaign meeting would be organised for January 2014.

(Johnny Connolly)

1. A full report of the meeting is available at: www.citywide.ie/publications
2. The community representatives are: Joan Byrne and Ger Kirby, Drug Advisory Group (DAG); Declan Byrne and Gary Broderick, National Advisory Committee on Drugs and Alcohol (NACDA); Teresa Weafer, National Drug Rehabilitation Implementation Committee (NDRIC); and Fergus McCabe, Oversight Forum on Drugs (OFD). See video at: http://www.youtube.com/watch?v=7hLf7D2n33g
3. See Brian Harvey's presentation at: http://www.youtube.com/watch?v=JtqYABr6adY

Travellers accessing addiction services in Ireland

A recently published paper based on data from the National Drug Treatment Reporting System (NDTRS) for the years 2007–2010 describes individuals from the Traveller community who were assessed or treated for problem drug or alcohol use.[1] This study provides an insight into the needs of Travellers with problem substance use and will be useful in informing and developing policies and strategies to tackle barriers and issues faced by the Traveller community.

Since 2007 the NDTRS has recorded ethnic identifiers comparable with those used by the Central Statistics Office in the Census. The inclusion of an ethnic identifier question in routine data collection allows the recording of useful information on ethnicity for planning health services.

Key findings

Numbers seeking treatment

In the period 2007–2010, 68,748 cases sought treatment for problem substance use and were reported to the NDTRS. Ethnicity was recorded for 68,329 cases (99.4%), of whom 1,098 (1.6%) identified themselves as Irish Travellers. The number of such cases increased by 163% in the four-year period, from 162 in 2007 to 427 in 2010. However, the authors note that the number of Traveller cases recorded in the routine national drug treatment data is likely to be underestimated.

Travellers accessing addiction services *(continued)*

The incidence of treated problem substance use among the Traveller community was three times that among the general population in 2010 (523 per hundred versus 173 per 100,000).

Main problem substance

- Alcohol was the most common problem substance for which cases both from the Traveller community (42.3%) and from the general population (52.7%) sought treatment.
- The number of Travellers seeking treatment for opiates (heroin, methadone and other types) increased by 291% (from 43 cases in 2007 to 168 in 2010), comprising 36.0% of Traveller cases in the four-year period, compared to 28.7% of cases from the general population.
- Although the numbers were small, there was a sharp increase in cases of Travellers reporting their main problem substance as benzodiazepines (a 240% increase, from 5 in 2007 to 17 in 2010) and cannabis (a 200% increase, from 16 in 2007 to 48 in 2010). A similar upward trend, if less pronounced, was observed in cases from the general population: benzodiazepines (a 146% increase, from 177 to 435 cases) and cannabis (a 118% increase, from 1,065 to 2,326 cases).
- Opiates (heroin and other types) were the most commonly reported problem substance among Traveller women, while alcohol was the most commonly reported among women from the general population.
- Albeit small in number, the proportion of Traveller women treated for benzodiazepines as a main problem substance (9, 4.0%) was higher than that in women from the general population (328, 1.9%).

Additional problem substances

- The proportion reporting problem use of more than one substance (polysubstance use) was higher among Traveller cases (523, 53.2%) than among cases from the general population (24,826, 42.1%). The proportion reporting problem use of more than one substance was higher amongTraveller men (425, 56.1%) than Traveller women (98, 43.4%).
- Cannabis was the most commonly reported additional problem substance among both Traveller cases and cases from the general population. Alcohol, cocaine, and benzodiazepines were the next most frequently reported additional problem substances for both groups.

Age first used drugs

- Traveller men who had used drugs commenced their drug use at a younger age (median, 14 years) than either Traveller women (median, 16 years) or their male counterparts from the general population (median, 16 years).
- Traveller women who had used drugs commenced their drug use at an older age (median, 16 years) than women from the general population (median, 15 years). The median period of time between commencing alcohol or drug use and seeking treatment was shorter for Traveller women compared with women in the general population.

Injecting risk

A slightly lower proportion of Travellers reported ever injecting drugs compared to the general population, (15.3% versus 18.1%), and injecting status differed for men and women.

The proportions of Traveller men who reported ever injecting or ever having shared injecting equipment were lower than those in the general population. Traveller men reported starting to inject at an older median age than men in the general population (22 versus 19 years).

A higher proportion of Traveller women reported ever having injected compared with women from the general population (24.3% versus 16.3%), and also started injecting at a younger median age than women from the general population (19 versus 20 years). The proportions of Traveller women who were injecting at the time of entry to treatment and who reported having shared injecting equipment were greater than those among women from the general population.

Gender differences

Traveller women reported high rates of problem opiate use and injecting behaviours, contrary to the perception that problem substance use in the Traveller community is a predominantly male issue. The findings present a major cultural issue and challenge to Traveller health services and, given the high level of sharing, this has implications for the delivery of needle exchange services.

The paper highlights that problem drug and alcohol use remains a serious issue, presenting 'complex and multiple challenges for health services providing treatment' and the specific needs and vulnerabilities of Travellers need to be considered in order to provide targeted, appropriate and effective addiction services.

(Anne Marie Carew)

1. Carew AM, Cafferty S, Long J, Bellerose D and Lyons S (2013) Travellers accessing addiction services in Ireland (2007 to 2010): analysis of routine surveillance data. *Journal of Ethnicity in Substance Abuse*, 12(4): 339–355. www.drugsandalcohol.ie/20892

National Registry of Deliberate Self Harm annual report 2012

The eleventh annual report from the National Registry of Deliberate Self Harm was published in September 2013.[1] The report contains information relating to every recorded presentation of deliberate self-harm to acute hospital emergency departments in 2012, giving complete national coverage of cases treated.

There were 12,010 recorded presentations of deliberate self-harm, involving 9,483 individuals, in 2012. This implies that one in five (2,527, 21%) of the presentations was a repeat episode. The rate of presentations decreased from 215/100,000 of the population in 2011 to 211/100,000 in 2012, a 2% decrease.

Forty-six per cent of self-harm presentations in 2012 were men and 44% were aged under 30 years. Four hundred and sixty-nine (4%) self-harm presentations were by those living in hostels or with no fixed abode. Presentations

NRDSH annual report 2012 *(continued)*

peaked in the hours around midnight and were highest on Sundays and Mondays: 32% occurred on these two days. There was evidence of alcohol consumption in 4,610 (38%) presentations and this was more common among men (42%) than women (36%).

Drug overdose was the most common form of deliberate self-harm reported in 2012, occurring in 8,284 (69%) such episodes. Overdose rates were higher among women (75%) than among men (62%). In 70% of cases the total number of tablets taken was known; an average of 30 tablets was taken in these cases. The average among men was 32 tablets and among women 28 tablets.

Forty-one per cent of all drug overdoses involved a minor tranquilliser (most commonly benzodiazepine), 28% involved paracetamol-containing medicines, 22% involved anti-depressants or mood stabilisers (anti-depressant drugs known as Selective Serotonin Reuptake Inhibitors [SSRIs]) and 10% involved a major tranquilliser. Compared to 2011, a significant reduction was observed in the involvement of street drugs in intentional drug overdose acts, with a fall of 10% in 2012, which followed a 27% reduction in 2011. This reduction is likely to have been associated with the ban on head shop drugs from August 2010 onwards.

The next steps, or referral outcomes, for the deliberate overdose cases were: 48% discharged home; 28% admitted to an acute general hospital; 10% admitted to psychiatric in-patient care; a small proportion (3%) refused admission to hospital; and 12% discharged themselves before receiving referral advice.

The report provides information on what is being or can be done to reduce the number of self-harm cases. In January 2012, the National Office for Suicide Prevention (NOSP) established a National Working Group to continue to address access to minor tranquillisers. The authors recommend that this working group also review the implementation of the paracetamol legislation and prescribing patterns of SSRIs.

The authors report that alcohol continued to be one of the factors associated with the higher rate of self-harm presentations on Sundays, Mondays and public holidays, around the hours of midnight. These findings underline the need for ongoing efforts to:

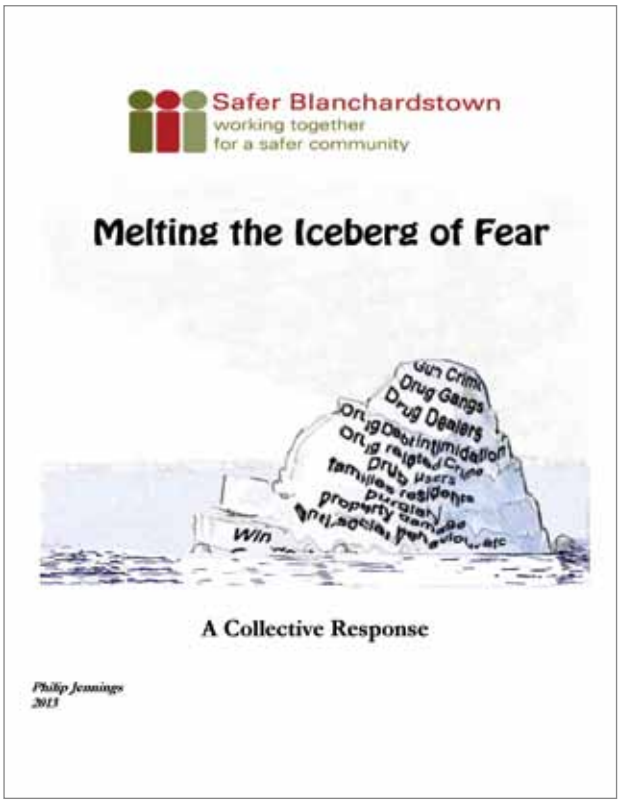
- enhance health service capacity at specific times and increase awareness of the negative effects of alcohol misuse and abuse such as increased depressive feelings and reduced self-control;
- intensify national strategies to increase awareness of the risks involved in the use and misuse of alcohol, starting at pre-adolescent age, and intensify national strategies to reduce access to alcohol and drugs;
- educate self-harm patients and their families about the importance of reduced use of and access to alcohol; and
- arrange active consultation and collaboration between the mental health services and addiction treatment services in the best interest of patients who present with dual diagnosis (psychiatric disorder and alcohol/drug abuse).

The authors report that there was variation in the next care recommended to deliberate self-harm patients, and in the proportion of patients who left hospital before a recommendation, which ranged from 6% in the Southern Hospitals Group to 19% in the Dublin North East Hospitals Group. In 2012, a sub-group of the National Mental Health Clinical Programme Steering Group produced 'National guidelines for the assessment and management of patients presenting to Irish emergency departments following self-harm'. The group recommended 'that these guidelines be implemented nationally as a matter of priority'. In addition, the NOSP has funded pilot projects to implement and evaluate suicide and self-harm awareness training for all emergency department staff, and to improve assessment procedures for self-harm patients in Cork and Kerry, which is a collaborative initiative between Cork University Hospital and the National Suicide Research Foundation.

(Mairea Nelson)

1. National Suicide Research Foundation (2013) *National Registry of Deliberate Self Harm Ireland annual report 2012*. Cork: National Suicide Research Foundation. www.drugsandalcohol.ie/20507

Melting the iceberg of fear – drug-related intimidation in Blanchardstown



The issue of drug-related intimidation, much of it related to drug debt, has emerged as a major concern for many communities in Ireland recent years.[1] It is an issue that has been highlighted by community-based advocacy groups such as the Family Support Network and the CityWide Drugs Crisis Campaign at a number of recent conferences.[2] It has also been identified as a key issue in the National Drugs Strategy 2009–2016 (NDS). Action 5 of the NDS aims 'To develop a framework to provide an appropriate response to the issue of drug related intimidation in the community'.[3]

A study of the issue in Blanchardstown, West Dublin, undertaken by the co-ordinator of Safer Blanchardstown (the local community policing forum), sought to identify those most likely to engage in local intimidation and those most likely to be victimised by it.[4] The research also investigated the causal factors underlying intimidation with a view to informing possible interventions and responses by partner agencies and the wider community. Primary research involved a series of interviews with senior outreach staff from a number of local agencies, including youth projects, community drug teams, family support services, social workers, health workers and the local Garda drugs unit. These interviews, conducted in late 2011, were supplemented by minutes of local resident meetings on community safety and a broader literature review.

The resulting report highlights the complex and multi-layered nature of the phenomenon and recommends that responses to it must be systematic, co-ordinated and directed along a continuum of different 'orders' of intimidation: lower, middle and higher. The report uses the metaphor of an iceberg to link these different levels of intimidation, as illustrated on the right.

Lower order intimidation, according to the report, involves

> young children [aged 8–16] bullying, assaulting, stealing, vandalising and spreading fear within the community, often directed to do so by older siblings and friends. Children may be directed to intimidate those who are thought to be talking to the Gardaí/Local Authority. This intimidation can take the form of breaking of windows, property damage, name calling, racial slurs and harassment of [other] children in the street. (p.11)

Young people at this level, the study finds, are sometimes supported in such behaviour by older siblings, family and friends and experience a 'lack of parental control, boundaries or direction in their lives' (p.11).

In relation to lower-order intimidation the report highlights the importance of early interventions for young people who may be likely to become involved in such behaviour. One local initiative currently being piloted is the Interagency Working Agreement Group (IWA) for Mulhuddart/Corduff. This group has developed protocols for the sharing of confidential information between all agencies working with young children and their families in order to provide them with appropriate supports. The report recommends that

> The principal aim of the IWA should be, through the provision of appropriate supports, an increase in educational attainment, the reduction in the number of young people with a low school attendance, at risk of suspension/exclusion from school or who have come to the attention of Fingal County Council/Gardaí in relation to anti-social behaviour harassment or intimidation. (p.14)

The report also notes the potential of problem-oriented policing methods, with 'Garda problem solving' training currently being rolled out across Blanchardstown targeting agency staff and residents. This is a model of problem solving referred to as SARA (Scanning, Analysis, Response, Assessment) to inform multi-agency interventions.[5]

Middle-order intimidation, involving those aged between 13 and 20, some of whom are dependent drug users and dealers, is reported as the level at which 'most of the drug related intimidation takes place and from which stems the criminal activity that financially supports those caught up in addiction' (p.16). The report recommends the development of a Prolific and Priority Offender (PPO) approach, defined as 'an approach that effectively manages offenders who are identified as committing a disproportionate amount of crime and harm in their communities' (p.17). This approach involves a 'catch and convict' strand which 'requires that the criminal justice agencies work together to ensure effective investigation, charging and prosecution' of PPOs in as short a timescale as possible. It also incorporates a 'rehabilitate and resettle' strand, whereby PPOs are provided with a 'simple choice – the opportunity to reform or face a very swift return to court should they re-offend or fail to comply with the conditions of court orders' (p.18). This latter strand, the report states, must be supported through 'locally agreed and implemented rehabilitation plans' (p.18).

The higher order is described as 'where the serious players reside', that is, 'those gang members and leaders who actively defend and try to expand their share of the drugs

Drug-related intimidation *(continued)*

Source: Jennings (2013); graphic by Sam Nevin

market' (p.20). In describing the demand side of the illicit drugs market, the author provides an interesting analogy with the local pub:

> People who go to the pub daily or on a regular basis enable the landlord to pay the rent, heat, light and staff wage bills. It's at the weekend however; when the casual drinkers come out that the publican makes the real money. Likewise with the drug suppliers, it's at the weekend when the casual recreational users order their small bit of hash/cocaine etc. that the real money is made and it is this real money that attracts the serious violence. (p.20)

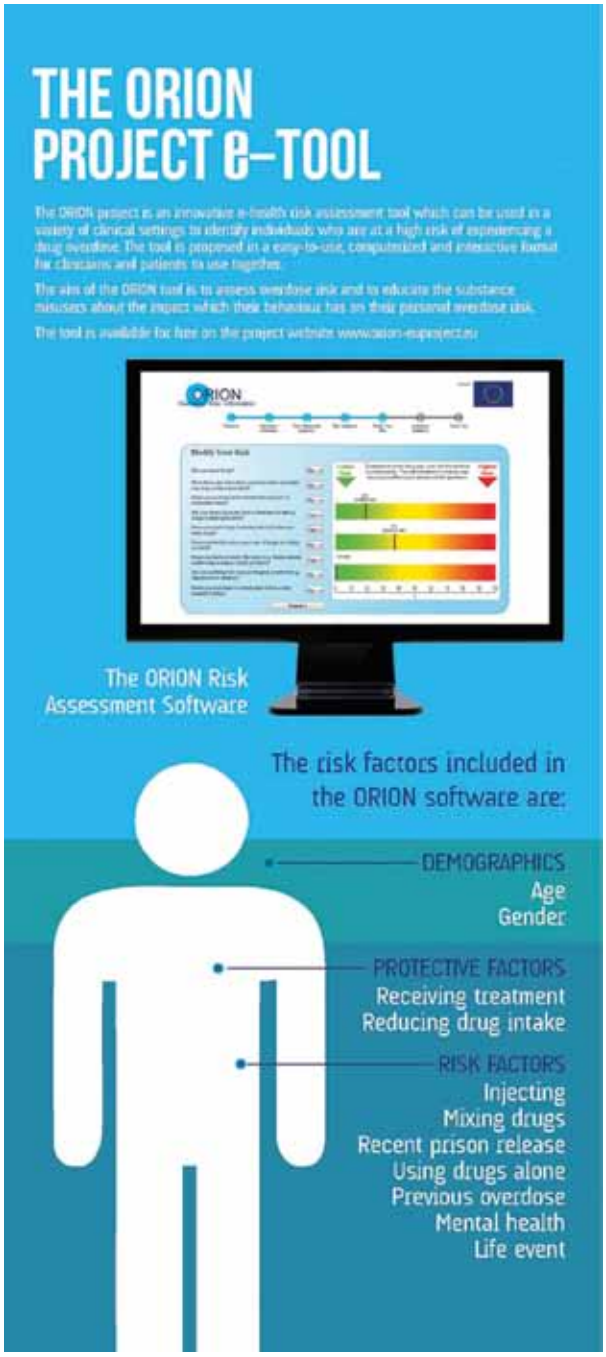
The report also employs the iceberg metaphor to illustrate the local impact of so-called gangland murders. When such a murder is committed, 'as a consequence of the interrelated nature of intimidation residents will attribute a relationship between those at the lower orders and those at the higher order even where this is not warranted. This fear will be picked up by those in the lower order whose swagger and power to intimidate will increase' (p.20), thereby leading to further fear and community submission and silence. The report stresses the need to expose the link between casual recreational drug use and such violence in communities.

One of the major consequences of drug-related intimidation is that its victims (both direct and indirect) refuse to engage with state authorities because of fear of reprisal from those involved in the drug trade. This report advocates the establishment of a community information network to gather information on intimidation whereby people could provide information to the gardaí and local authorities without committing to going to court. This would enable the authorities to build a profile of those involved and, by encouraging people to talk about the issues, it could enhance initiatives such as the support service provided by the National Family Support Network and the Garda National Drugs Unit to individuals and families facing intimidation.[6]

This report is an important local contribution to an issue that is not only increasingly of national significance but also extremely under-researched. The final recommendation highlights the need for further research 'in order to better inform workers, local communities and wider Irish society on how best to tackle this devastating behaviour' (p.25).[7]

(Johnny Connolly)

1. O'Leary M (2009) *Intimidation of families*. Dublin: Family Support Network. www.drugsandalcohol.ie/12898
2. Connolly J (2011) Citywide conference discusses drug-related intimidation. *Drugnet Ireland*, (36): 24–25.
3. Department of Community, Rural and Gaeltacht Affairs (2009) *National Drugs Strategy (interim) 2009–2016*. Dublin: Department of Community, Rural and Gaeltacht Affairs. www.drugsandalcohol.ie/12388
4. Jennings P (2013) *Melting the iceberg of fear: a collective response*. Blanchardstown: Safer Blanchardstown. www.drugsandalcohol.ie/20566
5. For further information on such techniques see the Centre for Problem Oriented Policing at www.popcenter.org
6. For further information about the drug-related intimidation reporting programme see the National Family Support Network at www.fsn.ie
7. The Citywide Drugs Crisis Campaign, in association with the Health Research Board, is currently conducting a national survey of drug-related intimidation and community violence in task force areas throughout the state. For further information contact the author.



The overdose risk information (ORION) project

The final report on the ORION project co-funded by the EU Drug Prevention and Information Programme was published in January 2013.[1] This project was set up to develop an e-health psycho-educational overdose risk assessment tool which could be implemented effectively in substance misuse fields across Europe. The model is based on known risk factors presented in an easy-to-use, computerised and interactive format for patients and health professionals to use together.

Using a clinical decision support framework, the tool collates patient-related information on demographics and protective and risk factors and by means of an evidence-based algorithm derives a risk estimate that is communicated to the clinician and the patient in a clinical interview.

The project was piloted in clinical settings which provided outpatient and inpatient treatment for opioid-dependent patents in four EU countries. A positive experience was reported by staff and patients, with a suggestion that the tool might be most useful to younger users, who were more likely to engage with the software.

Further research is recommended which could include ascertaining whether use of the tool

- changed patients drug use behaviour;
- accurately predicted overdose risk;
- was influenced by the interaction between healthcare staff and patients.

The report also recommends development of the ORION software to allow its wider dissemination across Europe, to include more risk factors and other drug use behaviours, and to enable its use on other platforms, e.g. mobile technology.

The ORION project e-tool can be downloaded from: http://orion-euproject.com/download-software/

(Ena Lynn)

1. ORION project (2013) *Overdose risk information EU project: final report January 2013*. European Commission: Brussels. http://orion-euproject.com/news-and-publications/

Alcohol consumption in early pregnancy and pregnancy outcomes

A recent study examined the association between maternal alcohol consumption in early pregnancy and pregnancy outcomes including low-birth-weight, spontaneous preterm birth and pre-eclampsia.[1] Many women continue to consume alcohol in pregnancy despite recommendations that they should abstain from alcohol in order to minimise potential risks to the fetus. The advice from the Departments of Health in Ireland and the United Kingdom (UK) and the Surgeon General in the United States is that alcohol should be avoided during pregnancy. However, the National Institute for Health and Clinical Excellence in the UK states that there is no consistent evidence of adverse effects from low to moderate prenatal alcohol consumption and recommends that women should be advised to drink no more than 8 grams of pure alcohol/1 standard drink once or twice a week.

This study involved 5,628 women who had not previously given birth, recruited in New Zealand, Australia, the UK and Ireland. Participants were interviewed at 15 weeks of gestation and information on alcohol intake before pregnancy and up to the time of interview was obtained using a standardised questionnaire. Alcohol intake was classified as occasional (8–16 grams of alcohol /1-1.5

Alcohol consumption and pregnancy *(continued)*

standard drinks per week), low (24–56 grams of alcohol /2.5-5.5 standard drinks per week), moderate (64–112 grams of alcohol/6-11 standard drinks per week), and heavy (more than 112 grams of alcohol/11 standard drinks per week). Binge alcohol consumption was defined as consumption of 48 grams of alcohol/5 standard drinks in one session.

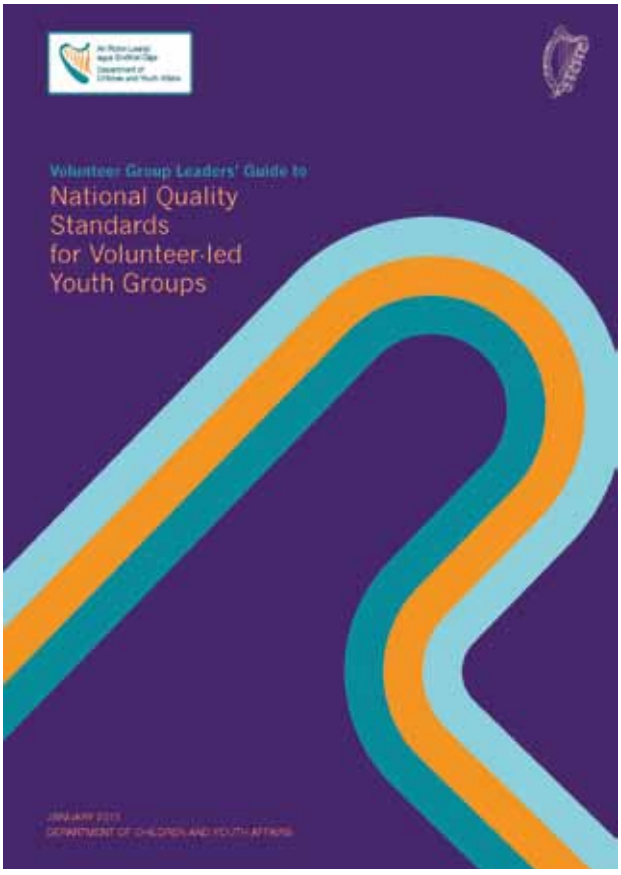
The majority of participants (60%) consumed some alcohol in pregnancy; 1,090 (19%) reported occasional consumption, 1,383 (25%) low consumption, 625 (11%) moderate consumption, and 300 (5%) heavy consumption. Overall, 1,905 (34%) participants reported binge drinking in the three months before pregnancy, and 1,288 (23%) reported binge drinking during the first 15 weeks of pregnancy. Significant geographical variation was observed between study centres: 65%–80% of participants in the UK and Ireland consumed some alcohol in pregnancy, compared with 38% in Australia and 53% in New Zealand. Participants who consumed occasional to heavy amounts of alcohol in early pregnancy did not have altered odds of a small-for-gestational-age neonate, reduced birth weight, pre-eclampsia, or spontaneous preterm birth. Similarly, those who binge drank in early pregnancy did not have altered odds of these adverse pregnancy outcomes.

The authors of the study concluded that there was no association between alcohol consumption before 15 weeks of gestation and small-for-gestational-age neonate, reduced birth weight, pre-eclampsia, or spontaneous preterm birth. It remains unclear whether any safe level of alcohol consumption in pregnancy exists, and there is currently inadequate information to determine whether there are discrete gestational windows of vulnerability for different adverse outcomes. It should also be noted that this study did not evaluate the association between alcohol consumption in pregnancy and long-term neurocognitive outcomes of children exposed as fetuses to alcohol. This potential for neurocognitive dysfunction remains one of the single most important reasons for pregnant women to avoid alcohol intake during pregnancy.

(Deirdre Mongan)

1. McCarthy FP, O Keeffe LM, Khashan AS *et al.* (2013) Association between maternal alcohol consumption in early pregnancy and pregnancy outcomes. *Obstetrics And Gynecology*, 122: 830–837. www.drugsandalcohol.ie/20527

New standards to support the voluntary capacity of youth work provision in Ireland



According to a recent report by Indecon[1] which assessed the economic value of youth work in Ireland, there are over 40 national youth work organisations in the sector responsible for providing services through local community-based projects and groups. It is estimated that 40,145 individuals work in a voluntary capacity in the sector and 1,397 full-time equivalents are employed in management, service delivery and training and support for volunteers.

In a move designed to support the large voluntary capacity within the youth sector, the Department of Children and Youth Affairs (DCYA) recently published a new set of quality standards to support volunteer-led youth groups in creating and providing quality, developmental and educational programmes and activities for young people in safe and supportive environments.[2] The standards are designed to:

- improve the quality of the programmes and activities provided;
- improve the way programmes and activities are planned and delivered; and
- provide young people with the opportunity to have a say in the development and review of the group and its activities.

The standards will be implemented with youth groups on a phased and incremental basis with a view to all youth groups in receipt of funding from the DCYA being engaged in the process from January 2014. It is expected that many of the groups funded by the DCYA will already be in a position to adhere to the standards and confirm that they have met each of the indicators of achievement. The standards are based on three core principles from which the indicators derive, as set out on p.1 of the guide:

New standards in voluntary youth work *(continued)*

One group of indicators in these standards calls for active involvement of young people in the planning, design, delivery and evaluation of volunteer-led youth services, and making services relevant to young people. This is an important dimension of these standards and echoes the wishes of young people when consulted on how to improve youth services. For example, the DCYA recently published a summary of the main issues to arise from a regional consultation with 239 young people in Sligo, Cork and Dublin.[3] Over half (57%) the cohort were female and 73% were aged under 18 years. When asked for their views on how existing activities in the youth sector could be improved, and for new ideas for clubs and activities, the main responses centered on young people having a more active say in running clubs and activities, more interaction with similar groups outside the clubs and greater diversity of activities in clubs.

Summary

In times of austerity and in the context of a struggle for access to scarce resources, it is important that we learn from and use information from research to design and deliver services that are fit for purpose. One way this can be achieved is by combining information from related research to develop 'logical linkages' between what at first may appear to be unrelated accounts. By way of illustration, take the three reports cited in this article. The Indecon report estimated that 40,145 individuals work in a voluntary capacity in the youth work sector, this figure can be used to establish a case for a programme of support to maintain and enhance the contribution of this large group of volunteers in the sector. One means of providing such support is to issue clear guidelines on the standards required by volunteers in their work with young people; this has now been done via the DYCA and the publication of the national quality standards for volunteer-led youth work. This illustrates that policy is responding to an identified need that came about via research. In turn, adherence to the standards will be partially assessed by examining the role played by young people in the planning, design, delivery and evaluation of youth services. This group of indicators of achievement is consistent with the desire for active participation expressed by a sizeable cohort of young people who use youth services, as described in the Young voices report; such linkage renders the indicators meaningful and relevant constructs. These three reports illustrate how 'logical linkages' can be gleaned from different research products and used to develop coherent policy and practice that link the need for services with provision and evaluation.

(Martin Keane)

1. Indecon International Economic Consultants (2012) *Assessment of the economic value of youth work*. Dublin: National Youth Council of Ireland. www.drugsandalcohol.ie/19045
2. Department of Children and Youth Affairs (2013) *Volunteer group leaders' guide to national quality standards for volunteer-led youth groups*. Dublin: Department of Children and Youth Affairs. www.drugsandalcohol.ie/20356
3. Department of Children and Youth Affairs (2013) *Young voices: have your say. Summary report*. Dublin: Department of Children and Youth Affairs. www.drugsandalcohol.ie/19479

Substance use prevention education in schools: an update on actions in the drugs strategy

It would appear that school-based universal substance use prevention education, particularly among second-level students, is moving towards an integrated hybrid model incorporating a whole-school approach to overall health and social education alongside an emphasis on development of personal and social competencies. It is not clear to what extent attention will be given to including substance-use-specific components in any such hybrid model, such as the Social Norms approach, where young people's perceived norms of substance use among their peers is directly challenged by empirical evidence.[1]

For example, actions 20 and 21 of the National Drugs Strategy (NDS)[2] relate specifically to improving the implementation of the Social, Personal and Health Education (SPHE) programme as the universal mechanism to prevent substance misuse in students attending both primary and post-primary schools. A progress report on the implementation of these and other actions contained in the strategy has recently been published by the Department of Health.[3] This report refers to proposed changes to the implementation of SPHE in the junior cycle (students aged 12–15 years) as part of a new overall framework, with the focus on promoting innovation within the school and developing identity within the student.

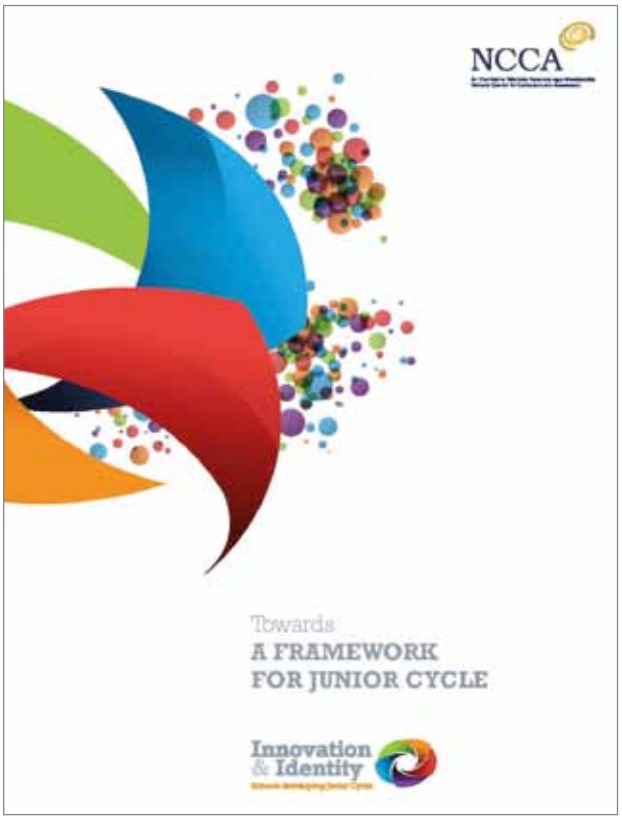
This new framework was published in 2011.[4] The framework is based on eight core principles, one of which is 'Wellbeing', whereby 'the curriculum contributes directly to the physical, mental, and social wellbeing of students' (p.10). The framework also includes five priority learning units, including one on 'looking after myself', and a set of eight key skills that students should master, including 'staying well' and 'managing myself'. Within this new framework SPHE will become a short course of 100 hours (as opposed to 60–70 hours at present). However, it would appear that the 100 hours may be spread across the three-years of the junior cycle. SPHE is one of twenty-four subjects listed on the curriculum and will be assessed at school level.

On programme evaluation, the framework document states:

The extent to which a school's programme supports students in developing key skills, improving literacy and numeracy, and in learning relevant to all the statements of learning will be evaluated in the first instance by the school itself through an on-going process of self-evaluation. (p.23)

This work will be supplemented by evaluation undertaken by the Department of Education and Skills through the schools inspectorate. One of the implications of incorporating SPHE within this broad curriculum framework for 12–15-year-olds is that it is not clear to what extent changes in knowledge, attitudes and behaviours around substance use will be measured as part of this evaluation.

The progress report on the NDS contains information on how teachers are being supported in implementing SPHE in schools. For example, at post-primary level a dedicated SPHE support service comprising six staff provides training, advice



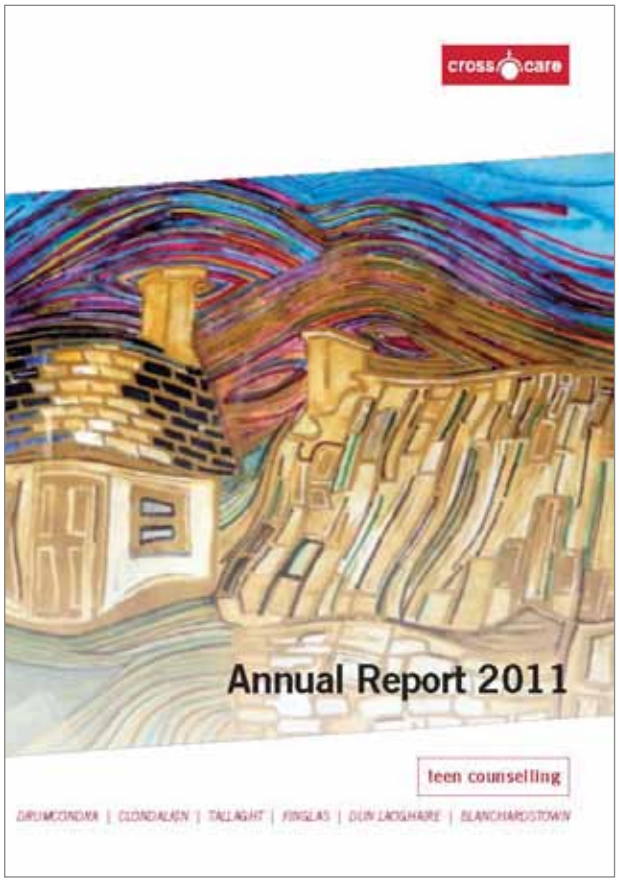
and support to schools. In the school year 2011/12, 3,949 teachers and other staff attended school-based events and 1,581 teachers attended cluster in-service training organised by the SPHE support service. The professional development service for teachers (PDST) provides support for teachers and schools. The website of the PDST now includes specific material on substance use. The following extract from the website[5] illustrates the philosophy underlying the delivery of substance use education in schools:

> Substance Misuse Prevention Education involves developing social and personal skills, fostering health promoting values and attitudes and giving age appropriate information, in that context on medicines and drugs, both legal and illegal. …Substance Misuse Prevention Education should not be treated differently to other areas of the curriculum or taught in isolation. Such approaches could have the effect of sensationalising it as a topic rather than treating it as an integral part of the holistic development and education of the pupil in the context of the primary curriculum. The teacher is the best placed person to deliver substance misuse prevention education in the school setting.

(Martin Keane)

1. McAlaney J, Bewick B and Hughes C (2011) The international development of the 'social norms' approach to drug education and prevention. *Drugs: education, prevention and policy*, 18(2): 81–89.
2. Department of Community, Rural and Gaeltacht Affairs (2009) *National Drugs Strategy (interim) 2009–2016*. Dublin: Department of Community, Rural and Gaeltacht Affairs. www.drugsandalcohol.ie/12388
3. Department of Health (2013) *National Drugs Strategy 2009–2016: progress report to end 2012*. Dublin: Department of Health. www.drugsandalcohol.ie/20159
4. National Council for Curriculum and Assessment (2011) *Towards a framework for Junior Cycle: innovation and identity*. Dublin: National Council for Curriculum and Assessment. http://ncca.ie/framework/doc/NCCA-Junior-Cycle.pdf
5. Downloaded from www.pdst.ie/node/812

Latest report from the Teen Counselling service



The Teen Counselling service operated by Crosscare, a voluntary organisation, aims to provide a professional counselling service for teenagers and their families who are experiencing emotional, behavioural and functional difficulties.

The service works in teams of two, usually a psychologist and a social worker, who initially assess the nature and severity of problems with the parents and teenagers who present. Subsequently, parents and teenagers are provided with individual counselling sessions and, when appropriate, combined sessions are scheduled; a consultant psychiatrist attends on a sessional basis. According to its latest annual report,1 for 2011, 'one of the founding principles of the service has been prevention of more serious difficulties, particularly in the area of substance abuse…' (p.35).

In 2011, 437 families attended the service, 281 new and 156 continuing from 2010. Of the 281 new teenage clients, 56% were aged under 16 years, 52% were female and 89% were attending second-level school. Nineteen per cent (n=52) reported using drugs, of whom 90% used hash, 10% used cocaine, 8% ecstasy and 6% solvents; 17% reported using pills/medicines. Twice as many males as females were using drugs, and over a fifth (22%) of all young people using drugs were aged under 16. Almost half (48%) of all new teenage clients reported drinking alcohol, of whom 20% were aged under 16; there were no notable gender differences in overall alcohol consumption. Twenty-four per cent (n=68) of new teenage clients smoked cigarettes, and the report notes that the percentage of smokers aged under 16 was double that in 2010; overall, there were slightly more girls smoking than boys.

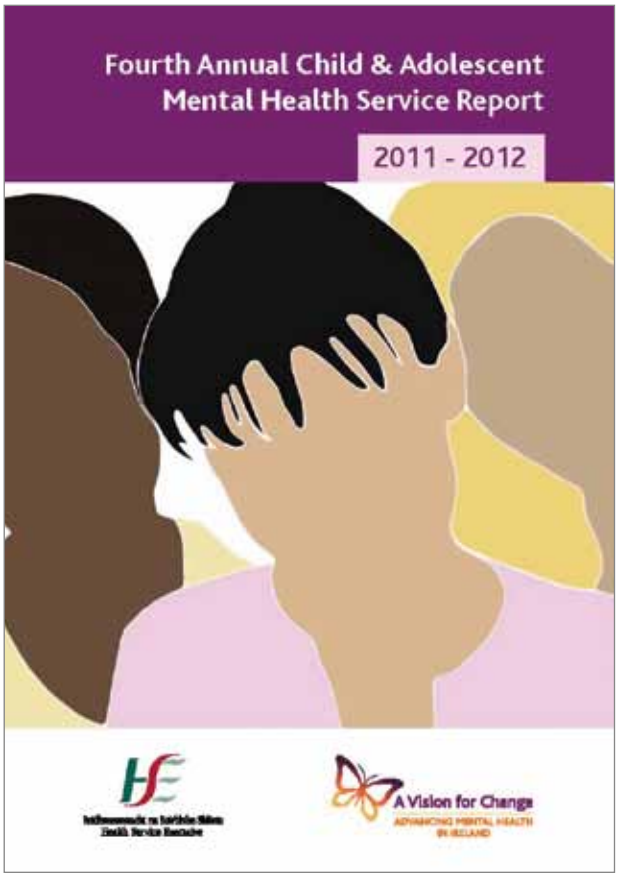
Behavioural problems in the home, school or community were the main reasons for referral of the majority (59%) of new teenage clients; 37% were referred because of family problems such as conflict or parental separation, and 36% for emotional problems such as anxiety. Relationship and communication problems were noted in 83% of families of new teenage clients. The percentage of new teenage clients reporting self-harm doubled from 11% in 2010 to 22% in 2011, and 21% of new clients reported suicidal ideation.

The main objective of the service is to support the normal systems that provide teenagers with stability, attachment and positive development, i.e. the home, the family and the school. Teenagers are invited to evaluate the extent of their main problems as they experience them at home, in school, with friends and with self, before and after counselling. In 2011, 25% (n=69) of teenage clients completed this evaluation. Improvement was reported in all four domains: 89% reported improvement in the home, 74% in school, 54% among friends and 88% with self. Thirty-two per cent (n=88) of parents completed the evaluation process; 90% reported a reduction in the severity of their problems and 93% reported improvement in their ability to cope with their problems. Improvements were also reported by counsellors in relation to the main problems families presented with and their underlying problems; counsellors noted improvements in some teenagers and in some of the families, who appeared to function better.

(Martin Keane)

1. Crosscare Teen Counselling (2012) *Crosscare Teen Counselling annual report 2011*. Dublin: Crosscare Teen Counselling. www.drugsandalcohol.ie/18348

Child and Adolescent Mental Health Service: report for 2011/2012



Child and Adolescent Mental Health Service (CAMHS) teams are the first line of specialist mental health services for children and young people. The multi-disciplinary teams include psychiatrists, psychologists, nurses, social workers, speech and language therapists and occupational therapists. The latest CAMHS annual report states that 63 such teams were in place in 2012.[1]

The report also shows that from October 2011 to September 2012 there was an increase of 17% in the number of referrals to the CAMHS teams. A total of 9,843 new cases were offered an appointment, 8,671 were seen and 1,172 did not attend. Of the 8,671 cases seen, 2,685 had been re-referred to the service. This number for re-referrals represents 31% of the new cases seen, continuing an upward trend in re-referrals since 2008 (which coincides with the onset of the economic recession and the implementation of fiscal austerity measures). Over the 12-month period 45% of new cases were seen within one month of referral and 66% within three months. According to the report, cases deemed urgent are seen as a priority while routine cases are placed on a waiting list. There were 2,056 young people waiting to be seen at the end of September 2012, an increase of 8% on the number waiting a year earlier.

During November 2011, an annual clinical audit was undertaken by 58 CAMHS teams who collected data on 8,479 cases seen during the month. Of the cases seen, 41.6% were aged 10–14, 28.4% were aged 5–9, 16.5% were aged 16–17, 12% were aged 15 and 1.4% were aged 0–4. The majority of referrals (64.6%) came from a general practitioner. Over a third (35.7%) presented with hyperkinetic disorders, including ADHD and other attention disorders, and 18.7% presented with anxiety disorders, including phobias, obsessive compulsive disorder (OCD) and post-traumatic stress disorder (Table 1).

Table 1 Primary presentation of 8,479 cases seen by CAMHS teams in November 2011

Primary presentation	Disorder	Number	%
Hyperkinetic disorders	ADHD and other attention disorders	3,025	35.7
Anxiety disorders	Phobias, OCD, post-traumatic stress disorder	1,588	18.7
Autistic spectrum disorders	Autistic disorder	947	11.2
Depressive disorders	Depression	798	9.4
Conduct disorders	Oppositional defiant behaviour, aggression, arson	580	6.8
Deliberate self-harm	Lacerations, substance overdose	285	3.4
Developmental disorders	Deficits in speech and social skills	217	2.6
Eating disorders	Pre-school eating problems, anorexia nervosa, bulimia nervosa	207	2.4
Psychotic disorders	Schizophrenia, manic depression, drug-induced psychosis	108	1.4
Habit disorders	Sleeping problems, bed-soiling	84	1.0
Substance abuse	Drug and alcohol misuse	30	0.4
Gender role identity	Problems with gender identity	16	0.2

Source: Health Service Executive, 2012

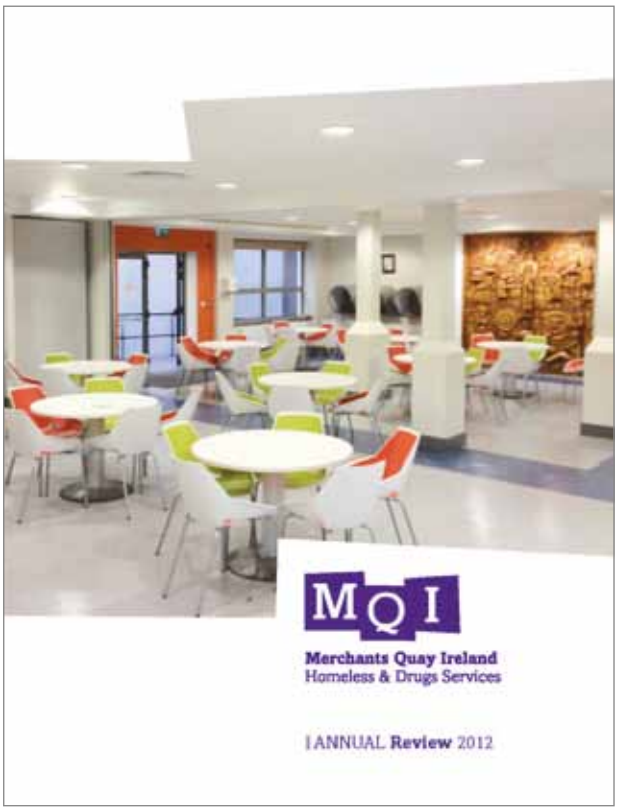
CAMHS annual report 2011/2012 *(continued)*

Males accounted for 64.9% of all children seen in November 2011 and were the majority gender in each of the age bands. Males made up the majority in all primary presentations apart from eating disorders, deliberate self-harm, depression and emotional disorders, where females were in the majority. Twenty per cent (n=1,684) of children seen by the service in November 2011 were in contact with social services.

(Martin Keane)

1. Health Service Executive (2012) *Fourth annual child & adolescent mental health service report 2011–2012*. Kildare: Health Service Executive. www.drugsandalcohol.ie/18890

MQI annual review 2012



The Merchants Quay Ireland (MQI) annual review for 2012 was launched on 6 September 2013 by the Minister for Social Protection Joan Burton TD.[1]

MQI's new facility, the Riverbank Centre, was officially opened by An Taoiseach Enda Kenny TD in 2012.

The New Communities Support Service provided one-to-one support to 239 service users. The largest number of new community clients were from Poland, accounting for 48% of clients seen.

MQI's needle-exchange service recorded approximately 20,847 client visits in 2012. The report highlights a continuing high level of demand for homeless services; 76,500 meals were provided by the day and evening services and 3,331 health-care interventions were provided in 2012.

In 2012 MQI continued to provide the national prison-based addiction counselling service to 13 prisons, employing 27 counsellors. Demand for this service increased by 17% over the 2011 figure, with 10,558 individual counselling sessions and 3,668 group attendances recorded. The counselling service co-ordinates an inter-agency programme at the medical unit in Mountjoy for nine clients per eight-week programme. Seven courses were delivered during 2012, with 59 participants and a completion rate of 92%.

MQI, in association with the Midland Regional Drugs Task Force and the HSE, administer the Midlands Family Support and Community Harm Reduction Service, providing outreach and working with families of those actively using drugs in that task force region. The service provided 190 group sessions and 610 individual sessions in addition to 818 supportive phone calls in 2012. The harm reduction service provided an average of 289 needle exchanges each month during the year. The Midlands Traveller Specific Drugs Project worked with up to 26 clients at a time and engaged in 555 support sessions. Athlone Open Door Centre recorded 2,424 visits, provided 2,392 meals, and had 119 clients during 2012.

The services offered by MQI and the numbers of people accessing them in 2012 are shown in the table below.

Service	Type of intervention	No. of participants	Outcomes
Needle-exchange and health-promotion services	- Promotes safer injecting techniques - HIV and hepatitis prevention - Safe sex advice - Information on overdose - Early referral to drug treatment services	- 3,639 used needle-exchange services, of whom 558 were new clients - 1,332 safer injecting workshops	
Stabilisation services	- Methadone substitution - Gateway programme	- 16 clients - 1,251 service visits	

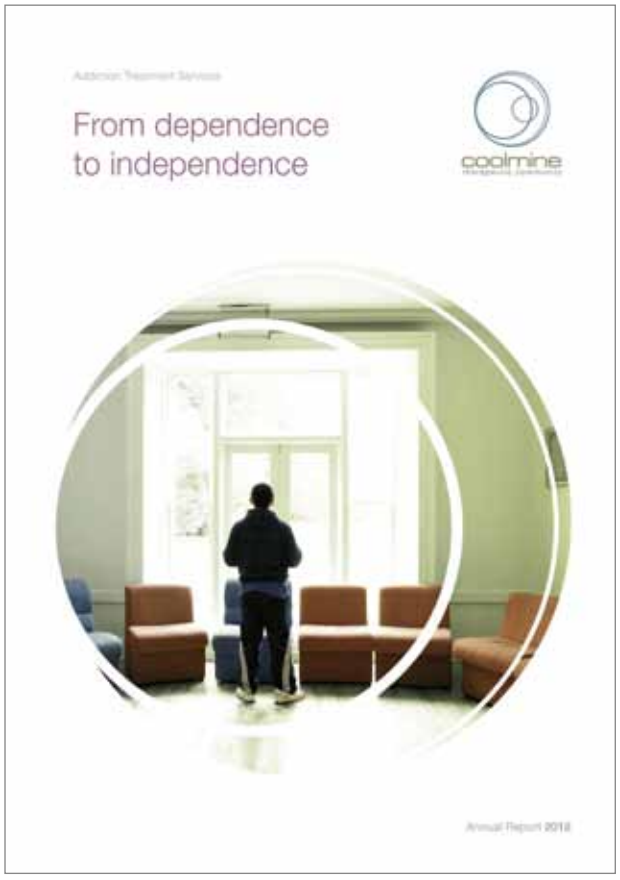
MQI annual review 2012 *(continued)*

Service	Type of intervention	No. of participants	Outcomes
Integration programmes	- Access to transitional accommodation Ballymount House - Leixlip House with Respond Housing Association	16 admissions to Aftercare Housing	Average monthly occupancy at Ballymount was 72%. Average monthly occupancy at Leixlip was 64%.
Training and work programmes	- Community Employment scheme	79 participants	Of the 32 who completed placements at Merchants Quay, 6 secured permanent employment, 2 moved to further education.
High Park	- 17-week, drug-free residential programme including individual counselling, group therapy, educational groups, work assignments and recreational activities	46 clients (of whom 9 were admitted for detoxification)	57% of clients completed the full programme.
St Francis Farm	- Therapeutic facility offering a 14-week programme. - Detox facility	49 admissions 38 clients	76% of clients completed detoxification.

(Vivion McGuire)

1. Merchants Quay Ireland (2013) *Annual review 2012*. Dublin: MQI. Available at www.mqi.ie

Coolmine Therapeutic Community annual report 2012



The Coolmine Therapeutic Community (CTC) annual report for 2012 was launched by Matt Cooper on 14 October 2013.[1] It contains information relating to services, statistics, strategic partners, funders and supporters, as well as a financial statement.

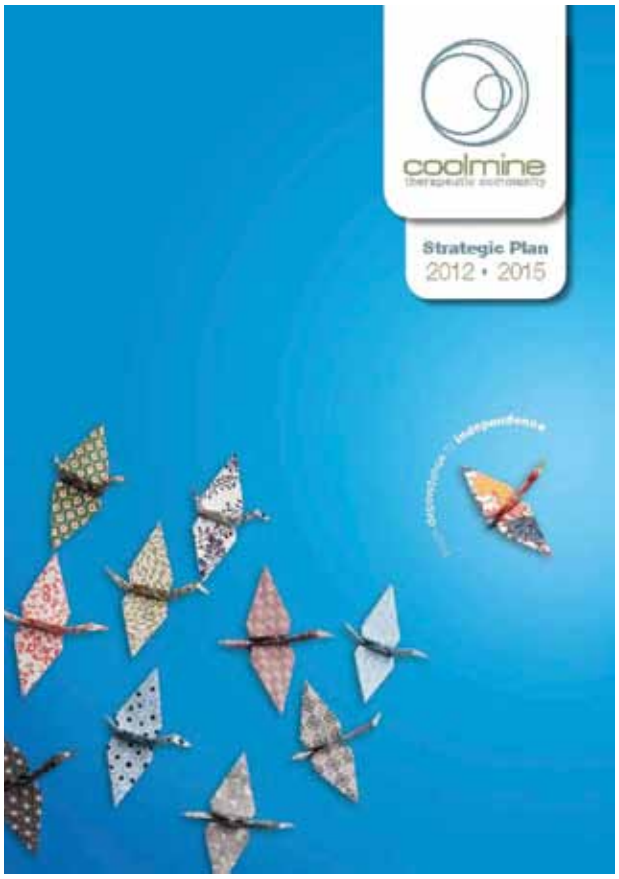
The report pays tribute to Mr Paul Conlon, CEO of Coolmine in the years 2004–2012, and highlights some of the organisation's achievements in 2012. The clinical team was enhanced with the appointment of a second full-time nurse, thanks to funding from the Baxter International Foundation; in addition, an organisational case manager and two psychotherapist counsellors were appointed.

A step-down programme was commenced to better support clients after residential treatment as they transition to wider community living. The family support services were strengthened through the introduction of the community reinforcement approach and family therapy programmes (CRAFT). Mindfulness-based relapse prevention programmes (MBRP) were piloted and implemented.

In 2012 Coolmine worked with over 1,000 individuals:

- The outreach team worked with 809 clients spanning both residential and day programmes.
- The drug-free day programme worked with 48 clients.
- 37 clients accessed the welcome programme.
- The women's residential service at Ashleigh House admitted 56 women, of whom 19 had their children permanently on site; 19 women completed a methadone detoxification programme.

Coolmine annual report 2012 *(continued)*



- The men's residential service at Coolmine Lodge admitted 120 men, of whom 12 completed a methadone detoxification programme.
- Family support services provided supports to 122 family members.
- 244 clients secured housing, including emergency, transitional, private, step-down and supported long-term accommodation.
- 155 clients were supported by the career guidance service.
- 65 clients were worked with in the new contingency management programme.

Coolmine's *Strategic plan 2012–2015*,[2] launched in May 2012, outlines the service's priorities for the next three to four years, including:

- Further refinements with respect to the length of stay and capacity within the residential programmes.
- Greater co-operation and formal service-level agreements with other service providers.
- Expansion of the detoxification capacity to include community-based alcohol detoxification.
- Development and provision of evidence-based alcohol awareness and mindfulness-based relapse prevention programmes.
- Completion and publication of the longitudinal research outcome study.
- Publication and dissemination of papers resulting from action research projects focusing on the implementation and integration of evidence-based treatments.

(Ita Condron)

1. Coolmine Therapeutic Community (2013) *From dependence to independence: annual report 2012*. Dublin: Coolmine Therapeutic Community. www.drugsandalcohol.ie/20706
2. Coolmine Therapeutic Community (2012) *Strategic plan 2012–2015*. Dublin: Coolmine Therapeutic Community. www.drugsandalcohol.ie/17610

Second report of the Suicide Support and Information System

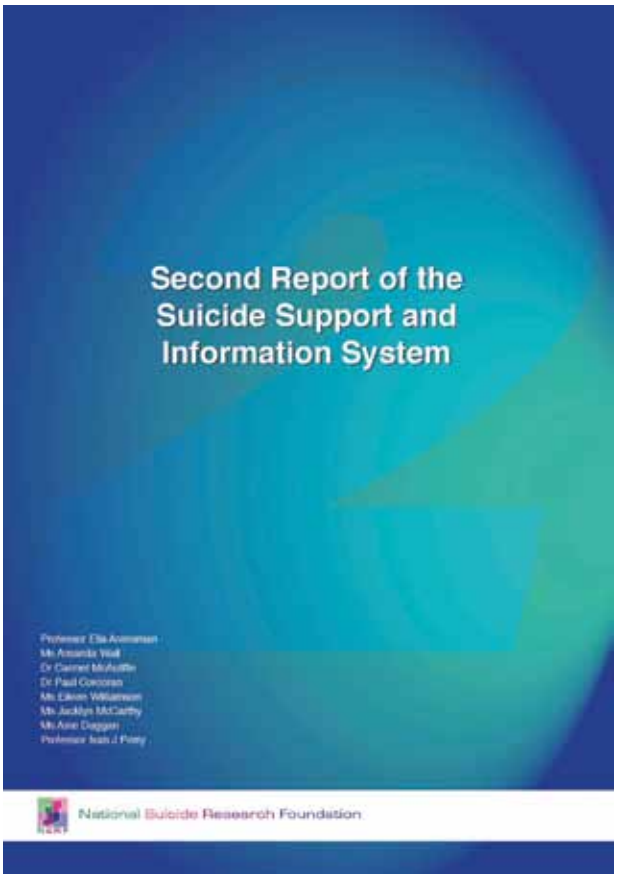
The second report of the SSIS[1] focuses on two areas: (1) investigating whether there are different subgroups among people who die by suicide, and (2) early identification of emerging suicide clusters using advanced geo-spatial techniques. The research team identified 275 cases of suicide and 32 deaths with open verdicts in Co Cork between September 2008 and March 2012. Coroner checklists were completed for all 307 cases.

The vast majority (220, 80%) of those who died with a verdict of suicide were men. The overall average age was 41 years, and men were significantly younger at the time of death (mean age 39 years) than women (mean age 46 years). The majority were Irish (93%), single (51%), and living in a house or flat (95%). Thirty-three per cent were unemployed, 22% were living alone and 2% were living in a supervised hostel. In terms of occupation, 41% had been working in the construction sector.

The majority (63%) of the 275 suicide cases died by hanging; 12% died by drowning and 10% by intentional drug overdose. Legal drugs used in the overdose cases included both prescribed (53%) and non-prescribed (46%) medication. Illegal drugs used included cocaine, ecstasy and heroin.

Of those with drugs in their toxicology results, just over one quarter (26%) had drugs above the therapeutic range, and 21% had multiple drugs recorded. In addition, benzodiazepines were recorded in 54% of cases, antidepressants in 39%, benzodiazepines in 54%, opiates in 39% and other drugs in 29%. Seventeen per cent of the total number of cases had taken medication and/or drugs in combination with other methods, such as hanging or drowning. A minority (14%) had used other methods, including cutting or stabbing, carbon-monoxide poisoning, firearms and jumping from a height or in front of a train. Close to one third (31%) of cases had left a note, in the form of a letter, e-mail or text message.

SSIS report 2012 *(continued)*



Sixty-one per cent of the suicide cases had a family history of mental disorder and the same proportion had a personal or family history of substance abuse. Over 39% of cases had either personal experience of significant physical, sexual or emotional abuse or a family history of such abuse. Ten per cent of fatalities had a parent or sibling who had a non-natural death, such as suicide, homicide or accident.

A history of self-harm was known for 132 cases, of whom 86 (65%) had engaged in at least one act of deliberate self-harm. Of these, 33% had engaged in one act, 14% in two acts and 10% in three acts. Twenty-seven per cent had engaged in deliberate self-harm in the 12 months prior to ending their lives, 14% less than a week before and 10% less than a day before.

Sixty-two (20%) cases were known to have experienced suicidal behaviour (fatal and/or non-fatal) by family members or friends at some point in their lives. Of these 62, 85% had a relative or close friend who had died by suicide and the remaining 15% had engaged in non-fatal self-harm. In eleven cases (18%) the deceased had lost three relatives or close friends by suicide.

A psychiatric assessment was known to have taken place in 123 cases. In the majority (69%) of these cases, mood disorder (such as depression) was the primary diagnosis, followed by anxiety disorder (6%), schizophrenia (5%) and alcohol, drug or alcohol and drug dependence/misuse (6%).

In the year prior to death, 173 of the cases had abused alcohol and/or other drugs. Of these cases, 49% had abused alcohol only, 28% had abused both alcohol and other drugs and 21% had abused other drugs only.

Suicide clusters

A total of nine statistically significant clusters were observed between August 2010 and June 2012. There was much overlap and nesting within these clusters, with two groups of clusters emerging. The report states: 'In order to illustrate a sample of the types of clusters that emerged, we detail two distinct clusters here that do not overlap in time or space' (p.26).

Cluster 1 involved 13 cases of suicide (12 men and one woman) in Co Cork over a three-month period, from April to June 2011. Nearly half the people (46%) had died by hanging and 38% had taken an overdose intentionally. At the time of death, 31% had used drugs, 23% had used alcohol and drugs, and 38% had a clear toxicology. More than one third (38%) had been diagnosed with a psychiatric illness and nearly two thirds (61%) had been diagnosed with a physical illness.

Cluster 2 involved seven cases of suicide (three men and four women) in Co Cork over a two-month period, from September to October 2011. The majority of the people involved had died by hanging, and the next largest number had died by jumping from a height. At the time of death, the majority had drugs only in their toxicology results.

(Mairea Nelson)

1. Arensman E, Wall A, McAuliffe C *et al.* (2013) *Second report of the Suicide Support and Information System.* Cork: National Suicide Research Foundation. www.drugsandalcohol.ie/20508

Justine Horgan – an appreciation

Dr Justine Horgan, senior researcher in the National Advisory Committee on Drugs and Alcohol (NACDA), died in August. Justine was a Health Research Board (HRB) staff member seconded to the Department of Health and worked as prevalence expert at the Irish National Focal Point to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Justine's colleagues and friends in the HRB were deeply saddened by her untimely death. Justine was a highly dedicated scientist with a commitment to ensuring that evidence of the highest quality was available to those making policy in the drugs field. We have lost an excellent colleague and a good friend and we will remember her time working with us with both fondness and regret.

In the paragraphs below, some of those who came to know Justine during her time in the Department of Health recall the projects on which they worked together.

Justine had a long and fruitful association with the National Advisory Committee on Drugs (NACD) before she was appointed as senior researcher in August 2010. She first started working with the NACD in the spring of 2006. She subsequently was responsible for designing a comparative study of substance use among early school-leavers and students attending school. The study had two key aims: first to explore the factors associated with substance use among those who left school early, and second to identify the risk and protective factors that influence young people's decisions regarding substance use.

The study was planned by the NACD on the basis of an initial literature review undertaken by Justine, who was also involved in the implementation of the study and in the process of data collection. The study was published and formally launched in the Gresham Hotel in October 2010, shortly after Justine took up post as senior researcher at the NACD.

The study involved a significant level of collaboration from inception through to publication, involving the research advisory group, Justine who conceptualised the study, her husband Peter Muhlau, the participants in the survey and the authors of the report. The process, which culminated in the largest study of substance use among young people ever undertaken in Ireland, reflects in many ways Justine's collaborative and co-operative style of working. We will remember the support and guidance she offered to the research advisory groups involved in this and other studies, the mentoring of her work colleagues, her generosity to those who sought her professional assistance and above all her dedication to carrying out high-quality research in the interests of evidence-based policy and practice in the field of substance misuse.

Susan Scally, Drug Policy Unit, Department of Health

Dr Justine Horgan first joined the NACD in 2006 having returned to Ireland from the Netherlands where she had worked in the University of Groningen. Her colleagues in the NACD welcomed the experience, enthusiasm and expertise that Justine brought to her role as a researcher and she made an immediate mark. Her first piece of work was *An overview of cocaine use in Ireland II* (NACD 2007). In addition to working on other ongoing projects she conceptualised and brought to fruition a novel and complex piece of work on early school leaving and the risk and protection factors, and carried out the pilot study.

In 2007 she accepted a position within the Department of Justice, working as a researcher with COSC, but rejoined the NACD in 2010. She led on the 2010/2011 general population survey while simultaneously managing contracts for new work. Further important research during this time was her work on children living with parents who use drugs. This work was published in her report, *Parental substance misuse: addressing its impact on children: a review of the literature* (NACD 2001). A subsequent national conference called 'A Family Affair' brought together professionals from a wide range of disciplines, including children's services, health, education, welfare and policy makers. The report and the conference generated enormous interest and contributed to the greater awareness of an area on which little research had been done.

Although I was familiar with Justine's work I only had the opportunity to meet her in person when I was appointed chairperson of the NACDA in January 2013. I would like to think we got on immediately. We shared a common passion for the work and for me it was like finding a new research friend who one sensed was going to be a 'best' friend and with whom one could share thoughts and excitement about shared research. We met and chatted and excitedly planned how we were going to get this or that piece of work done. The future of research was full of promise. To lose that unique best friend in research before we had time to really get to know one another and share the joy of the work has been a real loss. Personally, I feel a real sense of loss and regret, not so much for what we had shared but for what we might have shared.

Professor Catherine Comiskey, chair, NACDA

Justine Horgan *(continued)*

Justine was an instantly likeable person, with a great sense of humour and fun, and was an excellent mimic. She could talk about anything in a most engaging and interesting way, from the serious important life issues to the mundane. She was a generous and supportive work colleague and always had the time to explain and discuss her work and offer help and advice to everyone who asked for it. She was a lovely, graceful and elegant person who made a deep impression on everyone she met.

Mary Jane Trimble, NACDA

I was involved with Justine in relation to her research on parental substance abuse and its impact on children. As a member of the research advisory group, I got to know Justine as a senior researcher who had completed a comprehensive review and analysis of the international literature on the topic of the impact of parental substance misuse on children. Justine's research provided a sharp focus on the multiple losses and trauma experienced by these children and the actions required to lessen those harms.

The Croke Park conference was a fitting platform to communicate the findings from Justine's research to those to whom it was most directed – health and social care professionals, particularly those in child and family and addiction services. The report advocates common principles and standards to support work with parental substance misusers to underpin services working to safeguard the development of their children. I am pleased to say that Justine's work is bearing fruit in the form of a HSE national project steering group recently established for the development of a Hidden Harm policy as recommended in the *Steering group report on a national substance misuse strategy* (2012). The work of this group will be aimed at practice change, highlighting the importance of earlier interventions for children.

On a personal level, I am deeply saddened at the loss of Justine as her intellect, compassion, openness and humility have left an indelible imprint on the lives of those affected by addiction and those who work with them through the legacy of her fine research work.

Marion Rackard, HSE

My colleague Jo-Hanna Ivers and I carried out an evaluation of the roll-out of the pilot of the National Rehabilitation Framework between 2011 and 2013. It was not all plain sailing and Justine, through her membership of the National Drug Rehabilitation Implementation Committee (NDRIC), where she represented the NACDA, played a very constructive role in guiding the evaluation. She possessed a terrific combination of technical excellence with a gracious facilitatory disposition. She had a way of imparting advice in a non-condescending manner and it was impossible not to take her recommendations on board. We are a small drug research community in Ireland and Justine's tragic death has already had a huge impact on us, her colleagues. We can only imagine the greater sense of loss for Peter, her husband. I feel the better for having known her and worked with her.

Professor Joe Barry, TCD

From *Drugnet Europe*

Best Practice Portal revamp

Article by Marica Ferri in *Drugnet Europe*, No. 84, October–December 2013

The EMCDDA's Best Practice Portal (BPP) is a valuable web-based tool for disseminating information on effective interventions and their implementation across Europe. Since 2009, the EMCDDA has been collaborating with a number of international organisations at the forefront of research in this area in order to ensure that the portal is up-to-date, linked to relevant guidelines and standards and in line with advanced methods for disseminating evidence. Among the bodies consulted by the EMCDDA have been: the Cochrane Group on Drugs and Alcohol; the GRADE working group; and the EU-funded DECIDE project.[1]

In 2014, the BPP will be revamped with a view to becoming more user-friendly and better integrating its current components (synthesis of evidence, guidelines and standards and examples of implemented projects). With this in mind, experts convened in Lisbon on 22 October to discuss the new concept for the BPP and to test one of the evidence frameworks developed by the DECIDE project leaders (based on an EMCDDA systematic review on media campaigns to prevent illicit drug use among young people). The new, improved portal will be launched in May 2014 to coincide with the release of the European Drug Report 2014.

1. http://cdag.cochrane.org/ • www.gradeworkinggroup.org • www.decide-collaboration.eu

New series of EMCDDA papers to be launched this autumn

Cited from *Drugnet Europe*, No. 84, October–December 2013

In line with its 2012 Communication strategy which promises to produce briefer web-based products and fewer lengthy volumes in print, the EMCDDA will be launching this autumn a new series of 'EMCDDA papers' to be available in electronic format only. Upcoming topics to be addressed by the series include: drug policy advocacy organisations; psychiatric co-morbidity; public expenditure related to detainees for drug-law offences; multidimensional family therapy; and drug squads.

For more, see www.emcdda.europa.eu/publications/upcoming

Europe takes decisive step forward in monitoring drug supply

Cited from *Drugnet Europe*, No. 84, October–December 2013

A set of Council conclusions on improving the monitoring of drug supply in the European Union was adopted by the Economic and Financial Affairs Council meeting in Brussels on 15 November.[1] …

In order to obtain sound data in this area, the Council acknowledges the need for key indicators at EU level, developed around a set of sub-indicators (seizures; purity and content; drug prices; drug production facilities dismantled; drug law offences; drug availability in the population; and market size). The paper recommends an approach which builds on existing data-collection and reporting structures and ensures that activities are cost-effective, realistic, feasible and deliver clear value at EU level.

The need to scale up the monitoring of illicit drug supply in Europe is an important component of the current EU drugs strategy (2013–20). The strategy sets a priority for the EU to work towards more effective policies in the field of drug supply reduction, by reinforcing policy evaluation and analysis to improve the understanding of drug markets, drug-related crime and the effectiveness of drug-related law enforcement responses.

Member States are invited to collaborate with the European Commission, the EMCDDA and Europol with a view to improving the comparability and quality of data collected in the area of drug supply, as well as submitting available datasets to the agencies in a timely way, using existing reporting tools and channels.

1. 15189/13 CORDROGUE 107 ENFOPOL 329.

Implementing Decision submits new drug 5-IT to EU-wide controls

Cited from article by Andrew Cunningham and Ana Gallegos in *Drugnet Europe*, No. 84, October–December 2013

The Council of the EU adopted an implementing Decision on 7 October to submit the new psychoactive substance 5-(2-aminopropyl)indole (5-IT) to EU-wide control measures, following a risk assessment conducted by the extended EMCDDA Scientific Committee on 11 April 2013.[1]

5-IT, a synthetic stimulant drug, was reported to the EU early-warning system (EWS) in 2012 and appears to have been available in Europe since around November 2011. The substance was linked to 24 fatalities and 21 non-fatal intoxications, which occurred over a period of five months in 2012, raising concerns for public safety. …

By 13 October 2014, Member States must take the necessary measures, in accordance with their national law, to subject 5-IT to control measures and criminal penalties, as provided for under their legislation complying with their obligations under the 1971 United Nations Convention on Psychotropic Substances.

1. Risk-assessment report: http://register.consilium.europa.eu/pdf/en/13/st08/st08693.en13.pdf

Drugnet Europe is the quarterly newsletter of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). ***Drugs in focus*** is a series of policy briefings published by the EMCDDA. Both publications are available at www.emcdda.europa.eu.

If you would like a hard copy of the current or future issues of either publication, please contact:

Health Research Board, Knockmaun House, 42–47 Lower Mount Street, Dublin 2.

Tel: 01 2345 148; Email: drugnet@hrb.ie

National Documentation Centre on Drug Use

During 2013 the National Documentation Centre on Drug Use (NDC) expanded existing online resources and introduced some new services. The NDC works with researchers and practitioners throughout the drugs and alcohol sector to make research-based knowledge available and useful to people in their work and study.

Evidence reviews for drugs and alcohol taskforces

As part of its work in supporting the use of research in decision making the NDC is commissioning a series of rapid evidence reviews related to actions in the National Drugs Strategy. An evidence review attempts to answer a specific research question regarding the selection or implementation of an intervention or initiative. It synthesises existing evidence and provides information on what is likely to work in a particular setting. The first two reviews, to be completed in early 2014, will look at the topic of prevention work outside the school setting and the contribution of community-based treatment services to recovery outcomes.

Online course in evidence-based practice

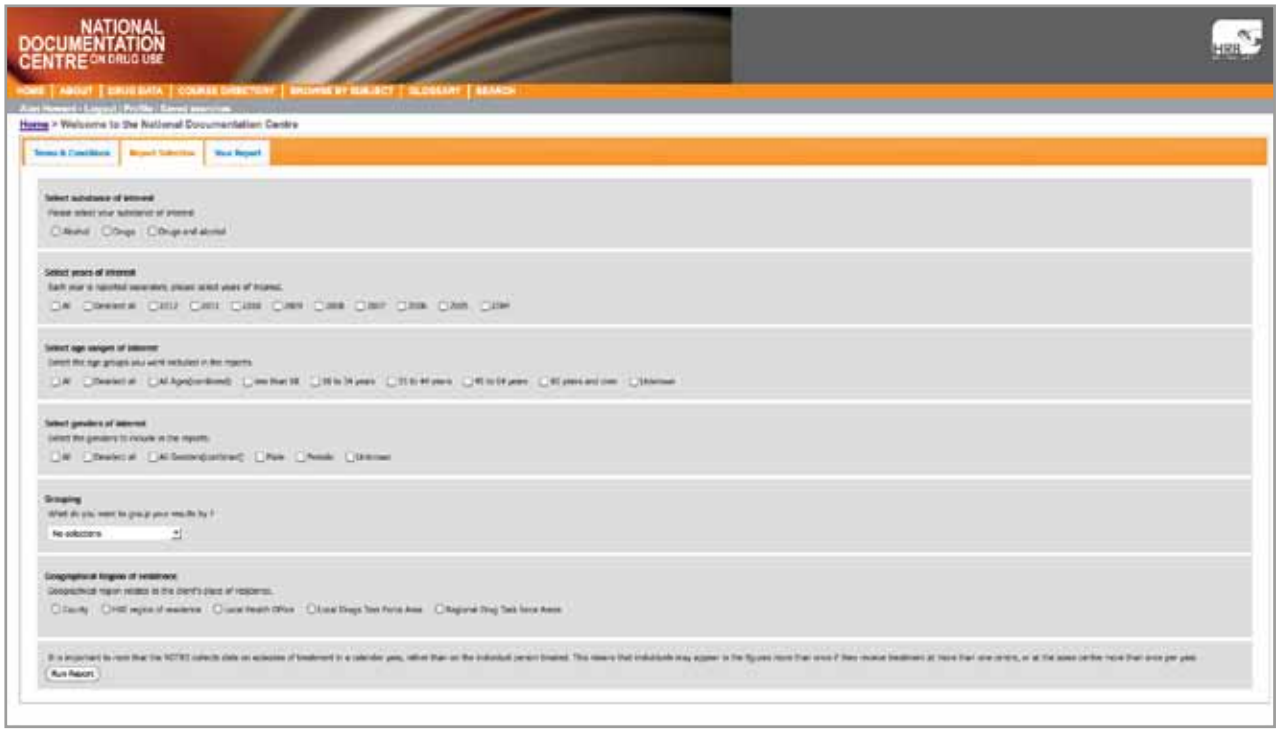
Beginning in March 2014, the NDC will run its online course in *Evidence-based practice for substance use prevention work*. The course was first delivered in 2010, and again in 2011. The aim of the course is to teach the principles of research-based practice to practitioners and to promote a scientific approach to prevention work and policy. The five modules of the course run over one semester of 12 weeks (80 hours) covering the following topics: the policy context; the evidence for drug prevention interventions; searching the scientific literature; critical appraisal; and data sources. Each of these topics is covered in separate two-week modules which include a number of recorded presentations prepared specially for the course by experts in the various topics.

The course adopts a problem-based learning approach. Course participants must identify a problem connected with their own work and use the skills they have learned during the course to find evidence which points to a solution to this problem. At the final face-to-face session each participant contributes to a group presentation outlining the approach they took to solving the problem. The technical skills learned through the course are reinforced through peer learning and are complemented by knowledge sharing and collaborative working.

The course is designed for practitioners and managers who work in the substance use education and prevention areas. Participants might include workers in the areas of drug education, youth services, community education, community development, and health promotion, SPHE teachers and individuals or agencies who commission substance education services in school, youth and community settings. The course will begin in March 2014. Applicants are required to hold a recognised Level 8 qualification or equivalent. If you would like to find out more about the course please contact us at ndc@hrb.ie.

NDTRS drug treatment data for 2011 and 2012

Drug treatment data for 2011 and 2012 from the National Drug Treatment Reporting System (NDTRS) are now available in the DRUG DATA pages of the NDC website at www.drugsandalcohol.ie The database now contains nine years of drug and alcohol treament data that can be searched to produce customised reports. You can run analyses on the treatment data based on up to eight different types of drug, including alcohol, in various combinations. The variables available for analysis include year, age group, gender and geographical region of residence (county, HSE region, LHO, regional or local drugs task force area). The report of your analysis can then be exported into Excel.



When interpreting the data, it should be remembered that each NDTRS record relates to a treatment episode (a case) and not to a person. Because there is currently no unique health identifier system in place in Ireland, the same person can be counted more than once in a reporting year if they had more than one treatment episode in that year.

Before using this resource you will be asked to accept a number of terms and conditions of use. These conditions protect the identity of NDTRS clients and the integrity of the data. We also ask that the NDTRS is acknowledged when data from the tables are used in a publication or presentation, and that the NDC receives copies of any publication in which these data are used.

Table of contents alerts

You can now sign up for Table of Contents (TOC) alerts for a number of drug and alcohol journals to which the NDC subscribes. Once logged in as a registered user you can sign up to have these alerts sent to your email address when new issues of the journals are published. This is an easy way to keep up to date with the latest research in your area of interest. When you click on the journal link in your email alert you can see the abstracts for the current issue of the journal displayed, as in the image below.

For further information contact the NDC at (01) 2345 175 or at ndc@hrb.ie

(Suzi Lyons and Brian Galvin)

Publications in International Journal of Drugs Policy *(Volume 24, Number 5, Year 2013)*

Refereed Articles

2013

[20] **Harms caused by China's 1906–17 opium suppression intervention** (James Windle), *In International Journal of Drug Policy*, volume 24, no. 5, 2013.

Abstract

Abstract Between 1906 and 1917 China (under the Imperial and then Republican regimes) enacted a highly effective intervention to suppress the production of opium. Evidence from British Foreign Office records suggest that the intervention was centred, in many areas, upon a highly repressive incarnation of law enforcement in which rural populations had their property destroyed, their land confiscated and/or were publically tortured, humiliated and executed. Crops were forcefully eradicated and resistance was often brutally suppressed by the military. As few farmers received compensation or support for alternative livelihood creation the intervention pushed many deeper into poverty. Importantly, the repressive nature of the opium ban appears to have been a contributing factor to the fragmentation of China, highlighting the counter-productivity of repressive interventions to reduce drug crop production.

Keywords

Drug law enforcement

() [bibtex] [pdf] [doi]

[19] **The OxyContin crisis: Problematisation and responsibilisation strategies in addiction, pain, and general medicine journals** (Emma Whelan, Mark Asbridge), *In International Journal of Drug Policy*, volume 24, no. 5, 2013.

Abstract

Background OxyContin® (Purdue Pharma, L.P., Stamford, CT) is now widely regarded as a drug of abuse fueling a larger opioid health crisis. While coverage in the North American press about OxyContin overwhelmingly focused upon the problems of related crime and addiction/misuse and the perspectives of law enforcement officials and police, coverage in those fields of medicine most intimately concerned with OxyContin—pain medicine and addiction medicine—was more nuanced. Methods In this article, we draw upon the constructivist social problems tradition and Hunt's theory of moral regulation in a qualitative analysis of 24 medical journal articles. We compare and contrast pain medicine and addiction medicine representations of the OxyContin problem, the agents responsible for it, and proposed solutions. Results While

Recent publications

Journal articles

The following abstracts are cited from recently published journal articles relating to the drugs situation in Ireland.

Availability of HIV prevention and treatment services for people who inject drugs: findings from 21 countries

Petersen Z, Myers B, Van Hout MC *et al.*
Harm Reduction Journal, 2013, 19 August, Vol. 10, Article no. 13
www.drugsandalcohol.ie/20531

This paper is a response to the need to monitor the state of the HIV epidemic as it relates to IDU and the availability of HIV treatment and harm reduction services in 21 high epidemic countries.

The overall proportion of HIV positive PWID in the selected countries ranged from 3% in Kazakhstan to 58% in Vietnam.

While IDU is relatively rare in sub-Saharan Africa, it is the main driver of HIV in Mauritius and Kenya, with roughly 47% and 36% of PWID respectively being HIV positive. All countries had antiretroviral treatment available to PWID, but data on service coverage were mainly missing. By the end of 2010, uptake of needle and syringe programmes (NSP) in Bangladesh, India and Slovakia reached the internationally recommended target of 200 syringes per person, while uptake in Kazakhstan, Vietnam and Tajikistan reached between 100-200 syringes per person. The proportion of PWID receiving opioid substitution therapy ranged from 0.1% in Kazakhstan to 32.8% in Mauritius, with coverage of less than 3% for most countries.

The authors conclude that In order to be able to monitor the impact of HIV treatment and harm reduction services for PWID on the epidemic, epidemiological data on IDU and harm reduction service provision to PWID needs to be regularly collected using standardised indicators.

A qualitative study of Irish postgraduate students' alcohol consumption

Hogan G and O'Loughlin D
Journal of Substance Use, 2013, 3 September, Early online.
www.drugsandalcohol.ie/20504

This exploratory qualitative study investigated Irish postgraduate students' experiences of alcohol consumption and the motives that work to encourage their engagement in the consumption practice. Utilising a non-probability purposive sampling method, seven semi-structured in-depth interviews were conducted with postgraduate university students from a range of academic disciplines. The findings of the research indicate that, during their studies, these young people underwent an important transition regarding the manner in which they engage in alcohol consumption. The excessiveness that characterised their initial behaviour as undergraduates has given way to a more restrained approach to alcohol consumption as postgraduates. A number of factors sustain this desire to adopt a more controlled approach to alcohol consumption, including an increasing sense of responsibility, critical self-reflection and experience gained. The research also provides valuable insight into the motives that continue to underlie engagement by this more mature group in the consumption practice, namely pleasure-seeking and the belief that drinking represents a form of expected behaviour.

The relationship between subjective life expectancy and self-reported alcohol use in Northern Irish adolescents

McKay, MT
Drugs: education, prevention and policy, 2013, 5 September, Early online.
www.drugsandalcohol.ie/20523

Aims: This study examined the relationship between subjective life expectancy (the subjective probability of living to age 75 years) and sex, type of school attended, year in school and self-reported adolescent drinking behaviours.

Methods: Participants were school children (aged 11–16 years) from post-primary (high) schools in Northern Ireland. Participants completed a questionnaire, including an assessment of subjective life expectancy, alcohol use and demographic measures.

Results: In bivariate analyses, there were significant differences in subjective life expectancy and sex, year in school, type of school attended and selfreported relationship with alcohol. Results of multinomial logistic regression, controlling for clustering at school level and socio-demographic measures, showed that more problematic drinking was significantly associated with a reduced life expectancy. Therefore, individual perceptions of subjective life expectancy accounted for some of the variance in problematic drinking above and beyond that predicted by socio-demographic factors.

Conclusion: Although there was an observed association between subjective life expectancy and selfreported alcohol use, future longitudinal research could assess the degree to which future time perspective predicts initiation into alcohol use and escalation into more problematic use among adolescents.

Surfing the Silk Road: a study of users' experiences

Van Hout MC and Bingham T
International Journal of Drug Policy, 2013, 24(5): 385–391.
www.drugsandalcohol.ie/20545

The online drug marketplace, called 'Silk Road', has operated anonymously since 2011. It is accessible through computer encrypting software (Tor) and is supported by online transactions using peer-to-peer anonymous and untraceable crypto-currency (bitcoins). The study aimed to describe user motives and realities of accessing, navigating and purchasing on the Silk Road marketplace.

Results: The majority of participants were male, in professional employment or in tertiary education. Drug trajectories ranged from 18 months to 25 years, with favourite drugs including MDMA, 2C-B, mephedrone, nitrous oxide, ketamine, cannabis and cocaine. Few reported prior experience of online drug sourcing. Reasons for using Silk Road included curiosity, concerns for street drug quality and personal safety, variety of products, anonymous transactioning, and ease of product delivery. Vendor selection appeared to be based on trust, speed of transaction, stealth modes and quality of product. Forums on the site provided user advice, trip reports, product and transaction reviews. Some users reported solitary drug use for psychonautic and introspective purposes. A minority reported customs seizures, and in general a displacement away from traditional drug sourcing (street and closed markets) was described. Several reported intentions to commence vending on the site.

Responsible vendors, intelligent consumers: Silk Road, the online revolution in drug trading

Van Hout MC and Bingham T
International Journal of Drug Policy, 2013, 7 November, Early online.
www.drugsandalcohol.ie/20888

Silk Road is located on the Deep Web and provides an anonymous transacting infrastructure for the retail of drugs and pharmaceuticals. Members are attracted to the site due to protection of identity by screen pseudonyms, variety and quality of product listings, selection of vendors based on reviews, reduced personal risks, stealth of product delivery, development of personal connections with vendors in stealth modes and forum activity. The study aimed to explore vendor accounts of Silk Road as retail infrastructure.

Vendors described themselves as 'intelligent and responsible' consumers of drugs. Decisions to commence vending operations on the site centred on simplicity in setting up vendor accounts, and opportunity to operate within a low risk, high traffic, high mark-up, secure and anonymous Deep Web infrastructure. The embedded online culture of harm reduction ethos appealed to them in terms of the responsible vending and use of personally tested high quality products. The professional approach to running their Silk Road businesses and dedication to providing a quality service was characterised by professional advertising of quality products, professional communication and visibility on forum pages, speedy dispatch of slightly overweight products, competitive pricing, good stealth techniques and efforts to avoid customer disputes. Vendors appeared content with a fairly constant buyer demand and described a relatively competitive market between small and big time market players. Concerns were evident with regard to Bitcoin instability.

Conclusion: The greatest threat to Silk Road and other sites operating on the Deep Web is not law enforcement or market dynamics, it is technology itself.

Characteristics of patients admitted to the intensive care unit following self-poisoning and their impact on resource utilisation

McMahon A, Brohan J, Donnelly M and Fitzpatrick GJ
Irish Journal of Medical Science, 2013, 8 October, Early online.
www.drugsandalcohol.ie/20696

Self-poisoning accounts for up to 10 % of hospital admissions, some of whom require admission to ICU. Few studies have looked at the epidemiology of these patients in an Irish setting. This study aimed to quantify the proportion of ICU admissions attributable to self-poisoning, to examine the characteristics and outcomes of these patients, and to assess their ICU resource utilisation.

ICU admissions from 2006 to 2010 were reviewed. Data were collected on patient age, sex, admission diagnosis, substances involved, APACHE II score, length of stay, organ support, and outcome. There were 80 admissions to ICU following self-poisoning, accounting for 3.8% of ICU admissions and 13% of all hospital admissions for self-poisoning. M:F ratio was 0.9:1. Mean age 35 (range 16–75), APACHE II score 14 (2–36). Commonest substances involved were benzodiazepines, opioids, tricycle antidepressants. Median ICU stay was 2 days, 84% of patients were ventilated, 27.5% required inotropic support, and 14% renal replacement therapy. When opioids were involved requirement for inotropes and CRRT were higher. ICU mortality was 6.3 %. These patients consumed 280 bed days.

Recent publications *(continued)*

Results: Self-poisoning accounted for 3.8 % of ICU admissions. Patients tend to require a short period of ventilation, with a minority requiring additional organ support. The cost of ICU care is calculated based on previously published methodology to be €7,717 per patient. Extrapolated nationally the annual cost for ICU care for self-poisoning is estimated to be in the order of €5 million.

The recovery ethos: towards a shared understanding

McDaid S
Irish Journal of Psychological Medicine,
2013, 8 October, Early online.
www.drugsandalcohol.ie/20681

This article presents Mental Health Reform's perspective on the recovery ethos for mental health service delivery derived from Irish stakeholders' perspectives. It arose out of a project to develop Mental Health Reform's agenda for advocacy to implement A Vision for Change. The article describes five core components of a recovery-orientated service: hope, listening, choice, partnership and social inclusion. The article also describes briefly how each component can be reflected in mental health service delivery. The recovery ethos can provide a way forward for service delivery within the current economic crisis and may be viewed as a tool for responding positively to the crisis rather than an additional burden.

Smoking cessation: a new approach

World of Irish Nursing & Midwifery, 2013, 21(7): 27.
www.drugsandalcohol.ie/20903

A new campaign is delivering real motivation and change for smokers based on an evidence-based digital coaching platform. Clinical intervention can be more successful if smokers can regard their smoking as preventing them from living a full life, rather than being the potential cause of their inevitable death. In response to this need, and in order to find a way to reach the 28 million smokers within the 25–34-year age group across Europe, the 'Ex-Smokers Are Unstoppable' campaign (www.exsmokers.eu) was developed to provide smokers with positive motivation to quit smoking for good. The campaign shifts the focus of smoking cessation from avoiding illness to the positive benefits of a smoke-free life: the ability to play sport and feel healthy, have more confidence and money, and hassle-free air travel. The campaign is underpinned by the scientific, evidence-based tool 'iCoach' – a free and clinically proven digital health coaching platform. Approximately 5,000 people in Ireland are registered on iCoach, with a self-reported quit rate of 40.1% after three months, compared to the average European self-reported quit rate of 36.8%.

Mediating effects of coping style on associations between mental health factors and self-harm among adolescents

McMahon E, Corcoran P, McAuliffe C *et al.*
Crisis, 2013, 34(4): 242–250.
www.drugsandalcohol.ie/21057

Background: There is evidence for an association between suicidal behaviour and coping style among adolescents.

Aims: The aims of this study were to examine associations between coping style, mental health factors, and self-harm thoughts and acts among Irish adolescents, and to investigate whether coping style mediates associations between mental health factors (depression, anxiety, and self-esteem) and self-harm.

Method: A cross-sectional school-based survey was carried out. Information was obtained on history of self-harm, life events, and demographic, psychological, and lifestyle factors.

Results: Emotion-oriented coping was strongly associated with poorer mental health and self-harm thoughts and acts. Problem-Oriented Coping was associated with better mental health. Mediating effects of Emotion-Oriented Coping on associations between mental health factors and deliberate self-harm (DSH) was found for both genders and between Problem-Oriented Coping and mental health factors for girls. Similar mediating effects of coping style were found when risk of self-harm thoughts was examined.

Limitations: Since the methodology used was cross-sectional, it is impossible to draw conclusions regarding causal relationships between coping style and associated factors. The coping measure used was brief. **Conclusions:** Promotion of positive coping skills and reduction of emotion-focused approaches may build resilience to self-harm thoughts and acts among adolescents experiencing mental health problems.

Adolescents exposed to suicidal behaviour of others: prevalence of self-harm and associated psychological, lifestyle, and life event factors

McMahon E, Corcoran P, Keeley H *et al.*
Suicide and Life-treatening Behaviour, 2013, 43(6): 634–645
www.drugsandalcohol.ie/21056

Exposure to suicidal behaviour of others was examined among 3,881 Irish adolescents in the Child and Adolescent Self-harm in Europe (CASE) study. One third of the sample had been exposed to suicidal behaviour, and exposed adolescents were eight times more likely to also report own self-harm. Exposed adolescents shared many risk factors with those reporting own self-harm. Those reporting both exposure and own self-harm presented the most maladaptive profile on psychological, life event, and lifestyle domains, but neither anxiety nor depression distinguished this group. Exposed adolescents are burdened by a wide range of risk factors and in need of support.

Self-cutting versus intentional overdose: psychological risk factors

Larkin C, Di Blasi Q and Arensman E
Medical Hypotheses, 2013, 81(2): 347–354.
www.drugsandalcohol.ie/21055

Individuals who present to emergency departments with self harm are at elevated risk of further self harm and suicide, and these risks are yet higher among patients who self-cut. Repetitive self-injury has previously been explained using a behaviourist approach focusing on operant conditioning, but we propose that the increased risk of self-harm repetition among those who present with self-cutting is at least partly mediated by pre-exis ting psychological risk factors.

Several studies show that those who present with self-cutting differ from intentional overdose patients on demographic, psychiatric and social factors, but, based on findings from community based studies, we hypothesise that there may be additional psychological differences that may also be associated with increased repetition risk. We conducted a small-scale cohort study of 29 self-harm patients presenting to A&E and compared theoretically-derived psychological variables between 8 self-cutting and 21 overdose patients. Those presenting with self-cutting scored significantly higher on hopelessness and lower on non-reactivity to inner experience and generally had a more vulnerable profile than those presenting with overdose. These findings support our hypothesis that the association between self-cutting and prospective repetition is at least partly due to pre-existing psychological vulnerabilities that increase both the likelihood of engaging in self-cutting as a method of self-harm and the likelihood of subsequent repetition of self-harm. Existing evidence suggests that self-cutting is a risk factor for repetition of self-harm, and it is possible that reducing and preventing repetition among these patients can be achieved by implementing psychological interventions to reduce hopelessness and increase tolerance of emotional distress.

'Let's Talk About Drugs' media award winners

The winners of the 'Let's Talk About Drugs' National Media Awards 2013 were announced at a ceremony in the Ashling Hotel in Dublin on 23 September.

Presenting the awards, Minister of State Alex White TD said:

> Targeting young people with prevention in mind is one of the most important things we can do and that's why I'm delighted to be involved in the 'Let's Talk About Drugs' National Media Awards ceremony today. It's great to see drugs and alcohol issues being debated in such a creative way and I am particularly pleased that the winning poster will inspire the forthcoming Dial to Stop Drug Dealing campaign.

Organised by the Greater Blanchardstown Response to Drugs (GBRD), the awards were created to encourage the journalists, reporters, film enthusiasts and animators of tomorrow to start writing and talking about the drugs and alcohol issue in Ireland today. The competition is supported by Drugs.ie, the HSE, The Department of Health, Crimestoppers and the Irish Examiner. Now in its seventh year, the competition attracted a record number of entries from schools, colleges and youth groups all over the country, with over 270 submissions received.

The themes for the 2013 competition were: Alcohol and sport – who is the real winner?; and Weed and health – are we making a hash of it? The judging panel included John O'Mahony (Irish Examiner), Henry McKean (Newstalk 106–108fm) and Caroline Twohig (TV3). They were joined by Jack Gleeson from the Dublin People Group, Andy Osborn from Drugs.ie, Marion Rackard from the HSE and Marie McBride from the Department of Health.

In all, 32 prizes were presented at the awards ceremony All category winners will have their features either published or broadcast in the media. The winners in each category are listed on the right. You can see a selection of the winning entries at: www.drugs.ie/resources/awards/

Overall National Media Awards 2013 winner

'What would you do?' by Robert Gaynor, Strandhill, Co Sligo

Film/Animation winners

12–14 years

Winner: Rober Gaynor, Strandhill, Co Sligo
Runner-up: Youth Advocate Programme, Blackpool, Co Cork

15–17 years

Winner: Presentation Secondary School, Thurles, Co Tipperary
Runner-up: Sphere 17 Regional Youth Service, Darndale, Dublin 17

18–20 years

Winners: Jessica Drew & Aoife Magee, Drogheda Grammar School
Runners-up: Rachel Quinn, Donal Martin & Una Curran, Dublin City University

21+ years

Winner: Ana Caceres, Letterkenny, Co Donegal
Runner-up: St Dominic's Community Response, Tallaght

Newspaper article winners

12–14 years: Darragh Elbel, Killarney, Co Kerry
15–17 years: Alice Kearns, Dalkey, Co Dublin
18–20 years: Aaron Elbel, Killarney, Co Kerry
21+ years: Clare O'Beara, Raheny, Dublin 5

Audio winners

12–14 years: Sean Downey, Midleton, Co Cork
15–17 years: Michael Dwyer, Gorey, Co Wexford
21+ years: Denise Woods, Mountshannon, Co Clare
Runner up: Gerard Click, Lotts Lane, Dublin 1

Poster winners

Winner: Edge YDP, Carrick on Suir, Co Tipperary
Runners up: Alyzza Marie Rodriguez, Crumlin, Dublin 12, & Vaida Balbieruite, Terenure,Dublin 6W

Cartoon winners

15–17 years

Winner: Lauren Vickers, Wicklow Town
Runner Up: Aislinn Fox, Birr, Co Offaly

18–20 years

Winner: Catherine Noonan, York Hill, Cork
Runner-Up: Jamie Barnes, Celbridge, Co Kildare

GBRD Spirit award

Joint winners: Scoil An Chroí Ró Naofa Íosa, Huntstown, & St Ciaran's NS, Hartstown, both in Dublin 15.

Upcoming events

(Compiled by Joan Moore – jmoore@hrb.ie)

February

6 & 20 February 2014

Managing the Performance Safety and Health Risks of Employee Drug and Alcohol Use

Venue: Dublin and Limerick
Organised by / Contact: EAP Institute
Email: anita@eapinstitute.com
Web: www.eapinstitute.com/drugalcohol.asp

Information: Since the introduction of the Safety Health and Welfare at Work Act 2005, the EAP Institute has been researching and developing a best practice training manual on workplace intoxicants which incorporates the requirements published by the Health and Safety Authority in 2011. These seminars, on **6 February at The Maldron Hotel in Dublin** and on **20 February at The Radisson Blu Hotel in Limerick**, will outline workplace intoxicant policy development, safety critical risk assessments, managing reasonable suspicion, reasonable accommodation and intoxicant testing. Speakers will include: Maurice Quinlan, Director of the EAP Institute, and Eddie Marks of Randox Testing Services.

March

19–20 March 2014

Cities for Youth conference

Venue: Hilton Reykjavik Nordica, Iceland
Organised by / Contact: City of Reykjavík and Youth in Europe
Email: congress@congress.is
Web: www.citiesforyouth.is

Information: Substance use among Icelandic adolescents has become the lowest in Europe. Reykjavík City celebrates this success in March 2014. How did Reykjavik City support adolescents in changing their behavior towards alcohol, smoking and drugs? How did the city involve local communities? Who joined forces? What actions where involved in building community cohesion and supporting youth? Find out at this English-language conference how the City of Reykjavik developed prevention programmes and their use of evidence-based data. Key-note speakers and workshops will inform us about the methods used to get us where we are today. Since 2006 the methodology from the Icelandic model has been introduced in several cities in Europe through 'Youth in Europe – A Drug Prevention Programme'.

April

3–4 April 2014

European Conference on Outreach Work 2014
Working together to reach and empower marginalized youth

Venue: The Oslo Kongressenter, Norway
Organised by / Contact: City of Oslo and national agencies
Email: outreachwork@congrex.no
Web: www.outreachwork.no/welcome

Information: The main focus of this conference will be on how the outreach workers understand, meet and engage with various groups of marginalized youths. There will be a special focus upon youths and young adults with an ethnic minority background. The conference will explore how new patterns of migration will shape new possibilities and challenges for young people in the margin of society. The Norwegian Directorate of Health, the Norwegian Institute for Alcohol and Drug Research and the Norwegian Association for Outreach Workers are organizing this conference jointly with the City of Oslo, Agency for Social and Welfare Services' Competence Centre and the Outreach Service. The conference has the support of several European networks working in the field. The program has been developed in close cooperation with our partner organizations to ensure a European perspective and high-profiled speakers for the plenary and workshop sessions.

May

7–9 May 2014

2nd European Harm Reduction Conference

Venue: Basel, Switzerland
Organised by / Contact: European Harm Reduction Network (EuroHRN) and the Swiss government
Email: harmreduction@infodrog.ch
Web: www.harmreduction.ch

Information: The 2nd European Harm Reduction Conference aims at promoting, at a professional level, the further development of the concept of harm reduction in the different European countries. Most recent research results, the current developments and challenges will be presented and widely discussed. The congress offers an ideal platform for dialogues so that the participants get to know models of best practice from various countries and receive ideas and inputs for their work. Furthermore, experiences can be shared, reflected upon, and compared in an international context.

21–23 May 2014

International Society for the Study of Drug Policy
Eighth Annual Conference

Venue: Rome, Italy
Organised by / Contact: International Society for the Study of Drug Policy (ISSDP)
Email: enquiries@issdp.org
Web: www.issdp.org

Information: This conference will focus on drug markets, the harms caused by both the supply of and demand for drugs, and the intended and unintended consequences of policy. In a first call for papers, the organisers are inviting abstracts (200–400 words) and panel proposals (for up to four papers) from researchers and practitioners interested in advancing knowledge regarding the development, assessment, or evolution of drug policy nationally or internationally (deadline: 20 January 2014 — cibb@uniroma2.it). PhD students and scholars from developing countries are encouraged to submit entries.

June

24–26 June 2014

Global Addiction Conference
Policy, Society, Alcohol and Emerging Issues in Addiction

Venue: Rome, Italy
Organised by / Contact: Global Addiction Association
Email: info@globaladdiction.org
Web: www.globaladdiction.org

Information: For 2014, in Europe, Global Addiction will retain its focus on the impact on society of addiction, including policy initiatives dealing with the difficulties associated with addictions. However, it will also focus on the problems caused by alcohol addiction to the individual, and how to treat these. We have also seen a considerable rise in recognition and prominence of a number of so called 'novel' addictions such as video game addictions, sex addiction, designer/club drugs, prescription drug addictions (eg. Opioid pain killers, sleeping pills, NSAIDS etc), gambling, cosmetic addictions (eg. amphetamine for weight loss, cosmetic surgery etc) … submissions on these topics will be well regarded for the conference.

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